



GrandFamilies: The Contemporary Journal of Research, Practice and Policy

Volume 2 | Issue 1

Article 1

2015

Complete Issue - Vol 2 Issue 1

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Recommended Citation

(2015). Complete Issue - Vol 2 Issue 1. *GrandFamilies: The Contemporary Journal of Research, Practice and Policy*, 2 (1).
Available at: <http://scholarworks.wmich.edu/grandfamilies/vol2/iss1/1>

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GrandFamilies: **The Contemporary Journal of** **Research, Practice, and Policy**

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*Research Article***Early Childhood Overweight and Obesity
In Multigenerational Households**

Chelsea O. McKinney, PhD, MPH
Northshore University Health System
Evanston, ILL

Abstract

This study explores the relationship between child weight status and grandmothers' coresidence up to age nine. Data is drawn from The Fragile Families and Wellbeing Study, a large nationally representative dataset of urban low-income families in the United States. Logistic regression estimates the association between grandmother coresidence and children's unhealthy weight status. Analyses were adjusted for child and mother characteristics, culture, race/ethnicity, SES, parenting practices, and built environment. Children who lived with a grandmother by age three were at increased odds of unhealthy weight levels, even after controlling for contributing factors. Grandmothers' influence on weight gain in three-year-old children appears to fade by age nine. Findings indicate that grandmothers' presence may present risks for the health of three-year-old children, and these risks should be further explored in future research. Explanations for this association are presented.

Keywords: childhood obesity, childhood overweight, multigenerational homes, grandmother coresidence

“Epidemic proportion” not only characterizes obesity prevalence among adults and adolescents, but even very young children (S. E. Anderson & Whitaker, 2009), especially those living in poverty (Irigoyen, Glassman, Chen, & Findley, 2008). Since 1980, obesity has more than doubled among preschool-aged children (Centers for Disease Control & Prevention [CDC], 2008). Twenty-one percent of preschool American children were overweight or obese in 2008 (Ogden, Carroll, Curtin, Lamb, & Flegal, 2010), while almost half of a low-income sample of young children were overweight or obese by age three (Irigoyen et al., 2008). Overweight during preschool years also persists into adolescence and young adulthood (Janssen et al., 2005; Nader et al., 2006; Singh, Mulder, Twisk, van Mechelen, & Chinapaw, 2008). Proponents of obesity prevention highlight early childhood as a critical stage during which overweight and obesity can develop (Freedman, Khan, Serdula, Ogden, & Dietz, 2006; Ogden et al., 1997; Sherry, Mei, Scanlon, Mokdad, & Grummer-Strawn, 2004; Singh et al., 2008; Strauss & Pollack, 2001; Whitaker & Orzol, 2006).

Many researchers who study obesity acknowledge that the family is an important environmental context for young children (Davison, Francis, & Birch, 2005; Hawkins, Cole, Law, & Group, 2009; Stein, Epstein, Raynor, Kilanowski, & Paluch, 2005). However, many studies of childhood obesity operationalize the “family” as parent-child interaction, overlooking how the family operates as a whole, which may include extended family (Birch & Ventura, 2009; Gibson, Byrne, Davis, Blair, Jacoby, & Zubrick, 2007; Golan & Weizman, 2001). Obesity has yet to be studied from a family systems perspective that goes beyond the parent-child dyad to consider

familial arrangements that include extended kin (Davison & Birch, 2001; Gruber & Haldeman, 2009). Such a perspective is especially appropriate given the changes in American family structures over the past few decades. U.S. Census data reveals that six percent of all children lived with a grandparent in 2008 (Child Trends, 2010). The present research aims to investigate the relationship between co-residence of grandmothers and the weight status among young grandchildren.

Limited research has examined grandmothers' influence on the health of young children living in poverty (Aubel, 2011). Pearce and colleagues (2010) addressed grandmothers' possible role in overweight children using an affluent British sample. The authors found that grandmother childcare was related to higher rates of being overweight among three year-olds. Neglecting relationships among extended family members may be a critical barrier to understanding unhealthy weight gain in children, particularly among disadvantaged populations. This paper examines early childhood excess weight and obesity through age nine in low-income families.

Theoretical Background

The biological process of weight gain is steeped in social context. Overweight is generated in part by interactions between biological susceptibility and environmental triggers (Marti, Martinez-Gonzalez, & Martinez, 2008). Therefore, a multi-contextual model is necessary to understand the complexity of this condition. Bronfenbrenner's bio-ecological model of human development best frames how we understand obesity, as it illustrates the interaction between organisms and their surroundings (Bronfenbrenner & Morris, 1998). The child's own biology, embedded within certain family and community environments,

may allow obesity to develop. Factors within the bio-ecological system frame our understanding about the causes of childhood obesity. These factors include child characteristics, culture and race/ethnicity, socioeconomic status, built environment, and parenting. Though not exhaustive, these factors are relevant for childhood obesity in multigenerational households. This study explores these variables across various contexts that are relevant for both childhood obesity within multigenerational households.

Culture and Race Ethnicity

Children of ethnic minorities are more likely to be obese (Bethell, Simpson, Stumbo, Carle, & Gombojav, 2010). At present in the U.S., Hispanic children are the most overweight or obese followed by African-American youth (Ogden, Carroll, Kit, & Flegal, 2014). Researchers suggest that ethnic minorities have different cultural ideals for body weight (Goodell, Pierce, Bravo, & Ferris, 2008; Kimbro, Brooks-Gunn, & McLanahan, 2007). African American and Hispanic mothers often consider an overweight baby a healthy baby (Rich et al., 2008; Syrad et al., 2014) and a thin baby a sign of deprivation and fragility (Baughcum, Burklow, Deeks, Powers, & Whitaker, 1998; Kaufman & Karpati, 2007). Even in a sample of children that included extreme cases of obesity, only 44% of African American parents or guardians identified their child's weight as a problem (Young-Hyman, Herman, Scott, & Schlundt, 2000). Hispanic and African-American children also engage in lower levels of physical activity than white children (Brodersen, Steptoe, Boniface, & Wardle, 2007; Eaton et al., 2008), perhaps reflecting less concern about body weight in their cultures (Gordon-Larsen, McMurray, & Popkin, 2000).

Eaton and colleagues (2008) report higher proportions of minority youth than Whites in inactivity levels, with up to a 36% difference between non-Hispanic Blacks' and Whites' sedentary behaviors. The present study uses a diverse sample, so that a cultural influence on childhood obesity in multigenerational homes can be identified.

Socioeconomic Factors

Regardless of ethnic background, higher educational attainment among parents is a protective factor against childhood obesity (Rasmussen et al., 2006). More educated parents tend to be more knowledgeable about healthy foods and appropriate portions for children. These parents are also more likely to eat healthier and follow pediatricians' dietary standards for feeding (Munoz, Krebs-Smith, Ballard-Barbash, & Cleveland, 1997; Rasmussen et al., 2006). Forty-four percent of children with parents educated at the graduate level complied with dairy product recommendations in one study, as opposed to 34% of children whose parents only had a high school education (Xie, Gilliland, Li, & Rockett, 2003).

In contrast to parents' education, the literature shows a positive association between maternal employment and child weight status (Cawley & Liu, 2012; Fertig, Glomm, & Tchernis, 2009). The rise of childhood obesity in America parallels that of women joining the work force. Labor force participation among American mothers with young children, in particular, has drastically increased since 1970, just as weight problems in children began to emerge in the U.S. (P. M. Anderson, Butcher, & Levine, 2003). One study found that increased hours of maternal employment over the child's life course are associated with increased likelihood of being obese (P. M.

Anderson et al., 2003). Researchers purport these associations are attributable to lack of time to prepare balanced meals, grocery shopping, and eating and playing with their children (P. M. Anderson et al., 2003; Cawley & Liu, 2012). Families with working mothers tend to consume fewer fruits, vegetables, and grains in exchange for “take out,” pre-prepared convenience foods, or restaurant meals higher in fat (Lindsay, Sussner, Kim, & Gortmaker, 2006).

At the same time, many low-income parents believe it is less expensive to purchase such convenience foods that have less nutritional value or are unsatisfied with the cost of healthy food (ConAgra Foods Foundation, 2012; Davison & Birch, 2001; Williams, Abbott, Crawford, & Ball, 2012). These households often struggle with food insecurity, in which there is not enough money to provide sufficient or balanced meals for the family (Dubois, Farmer, Girard, & Porcherie, 2006; Robaina & Martin, 2013). Children from low-income homes also tend to have less diverse and lower quality diets than higher income children (ConAgra Foods Foundation, 2012; Drewnowski & Eichelsdoerfer, 2010; Wolfe & Campbell, 1993). This paper disentangles socioeconomic status by controlling for parental education, parental employment, and proxies of family income to explain a potential relationship between grandmother’s presence and obesity in young children.

Built Environment and Child Lifestyle

Low SES families often cluster in economically depressed neighborhoods, which tend to foster poor eating habits. The concentration of fast food restaurants continues to exist as supermarkets are less available in low-income minority areas (Sallis & Glanz, 2006; USDA Economic Research Service,

2009), which drastically limits parents' selection of healthy foods (Morland, Wing, Diez Roux, & Poole, 2002; USDA Economic Research Service, 2009). Residents who have restricted access to supermarkets consistently pay more for healthier food substitutions (Cheadle et al., 1991; USDA Economic Research Service, 2009; Walker, Keane, & Burke, 2010).

Compounding the risk faced by families with fewer food options, urban sprawl in America has significantly decreased children's opportunities for regular physical activity. Most children travel to and from school by car or bus instead of walking or biking. A nationally representative study reports only a generation ago, at least half of children walked or biked to school compared to less than 25% today (Beldon & Stewart, 2003; The National Center for Safe Routes to School, 2009). Due to increased distance from the home to school, most parents deem it unsafe for children to walk or bike because of hazardous walking routes or crime. Neighborhood violence also makes recreational activity outside the home a serious risk for child safety (Brown III, Pérez, Mirchandani, Hoelscher, & Kelder, 2008; Kumanyika & Grier, 2006; Nichol, Janssen, & Pickett, 2010). Less time outdoors usually translates into more time spent watching television or using computers in this day and age (Rahman, Cushing, & Jackson, 2011; Sallis & Glanz, 2006). Increased sedentary activity during "screen time" is a common risk factor for obesity among today's youth (Robinson, 1999; Wijga et al., 2010). The present paper attempts to capture the effect of built environment on obesity by gauging access to food sources, and age-appropriate physical and sedentary activity in three-generation homes.

Parenting

While parents may have little control over the built environment in which they live, they are the primary architects of their home environment. Parents play an integral role in shaping children's food preferences (Birch, 1998; Scaglioni, Arrizza, Vecchi, & Tedeschi, 2011; Vereecken, Legiest, Bourdeaudhuij, & Maes, 2009). Exposure to healthy foods early in life increases children's preferences for those foods while limited exposure to healthy foods increase children's liking for prohibited foods. Parents' tendency to restrict junk food, for instance, can ultimately cultivate a penchant for low-nutrient snacks in children (Birch, 1998, 1999; E. L. Gibson et al., 2012). Research suggests that affective contexts in which children experience food greatly influence their preferences. Children learn to prefer foods served in a positive social atmosphere (E. L. Gibson et al., 2012). Parenting strategies can also influence children's capacity to self-regulate food intake. When given the opportunity to eat a food that is normally prohibited, children tend to eat more than necessary (Joyce & Zimmer-Gembeck, 2009; Savage, Fisher, & Birch, 2007). Restricting foods then shifts focus away from internal cues, like hunger or satiety, toward external cues like palatability and availability (Birch & Fisher, 1998; Joyce & Zimmer-Gembeck, 2009; Scaglioni et al., 2011).

Parents control other aspects of their home environment that impact energy expenditure, such as cognitive stimulation, physical activity, and sedentary behavior. Children in homes with low cognitive stimulation are at increased risk of obesity. High levels of television viewing, also linked to the occurrence of obesity in children (Boulos, Vikre, Oppenheimer,

Chang, & Kanarek, 2012; Dietz & Gortmaker, 1985; Zimmerman & Bell, 2010), is a good indicator of low cognitive stimulation, more sedentary behavior, and little physical activity (LeBlanc et al., 2012; Strauss & Pollack, 2001). Engaging children in public outings, to museums or the zoo for instance, are sources of cognitive stimulation and opportunities for exercise (Kimbrow et al., 2007).

Children also tend to model parents' behaviors, which include eating and exercising habits. In addition to shared genetic factors, modeling could explain consistent links found between parental obesity and child obesity, especially for mothers (Crawford et al., 2010; Klohe-Lehman et al., 2007; Oliveria et al., 1992; Stang & Loth, 2011). Fathers' weight status is less often associated with children's weight (Hood et al., 2000). Having two obese parents presents abundant risk beyond genetic predisposition for overweight in children (Mamun, Lawlor, O'Callaghan, Williams, & Najman, 2005). This study uses the convention of controlling for mothers' weight status as a proxy for an unhealthy home environment and genetic influence. Mothers' weight coupled with other parenting practices and health behavior controls, may help elucidate the process of young children's weight gain in multigenerational family context.

The study reported adjusts for child and mother characteristics, culture, race/ethnicity, SES, parenting practices, in addition to factors that are linked to childhood obesity including mother's health and health behaviors, child lifestyle, and built environment in order to explore how the experience of living with a grandmother influence overweight and obesity in children.

Method

Sample

The sample for this paper draws from the Fragile Families and Child Wellbeing Study, a nationwide birth cohort longitudinal study designed to track the life experiences of families at risk of adverse circumstances for children, including single parenthood and poverty. Purposive oversampling of children born to unmarried parents, roughly 75%, aims to capture family “fragility,” as unmarried parents are more likely to be minority and low-income. The Fragile Families Study follows almost 5,000 babies born between 1998 and 2000 in 20 large U.S. cities of 200,000 or more (Reichman, Teitler, Garfinkel, & McLanahan, 2001a).

Mothers and fathers were interviewed at the focal child’s birth, and later at ages one, three, five, and nine, totaling five waves of publicly available data. Enrollment began in 1998 and concluded with Wave 5 in 2010. Nearly all maternal interviews were conducted in person at enrollment, while 30% were administered by phone at one year and 98% by phone at years three and five (Bendheim-Thoman Center for Research on Child Wellbeing, 2008). The year-9 follow-up was primarily completed by telephone (Bendheim-Thoman Center for Research on Child Wellbeing, 2011). Parent interviews covered their mental and physical health, and socioemotional and socioeconomic resources. A subset (no less than 70% of the original sample) completed in-home interviews assessing home environment, child health and development at three-year, five-year, and nine-year follow ups. There were no significant differences between those who did and did not complete the in-home interview (Reichman, Teitler, Garfinkel, &

McLanahan, 2001b). Data used in the present study are derived from mother interviews in waves one through five and in-home assessments on non-Hispanic White, non-Hispanic Black, and Hispanic children who have valid information for the child weight status outcome. After excluding those children whose mothers identified as “other” ethnicities, the final sample of children with valid height, weight, and grandmother coresidence data for five waves summed to 3,101.

Measures

Weight status. Child weight status is assessed by calculating Body Mass Index [$BMI = \text{weight (kg)} / \text{height (m)}^2$], based on height and weight measurements at ages three, five, nine. Measurements were taken by trained interviewers using digital scales during the in-home survey. If the child was not able to be weighed alone, the mother was weighed while holding the child and her individual weight was subtracted from that amount. Mothers' BMI calculations are based on actual height and weight measurements unless they were pregnant, in the two pilot cities, or refused to be measured. BMI was not calculated with any self-reported values, which were excluded from analysis ($N=701$).

Children's gender-specific BMI-for-age percentile is categorized: normal weight ranging from fifth to 85th percentile. High weight is typically split into two categories: overweight (85th to 94th percentile) and obese (≥ 95 th percentile) (Barlow & The Expert Committee, 2007). Consistent with standard practice in the field (Ogden et al., 2014), this paper tests a larger range of risk by combining overweight and obesity (at or above 85th percentile) in the dependent variable as both levels are detrimental to child health (Paxson, Fink, & Brooks-Gunn, 2005).

Mother's weight status, a critical indicator of shared genetics and unhealthy home environment, is similarly categorized into overweight (25th to 29th percentile) and obese (at or above 30th percentile). These two adult categories remain separate covariates in the models presented here.

Grandmother coresidence. The primary independent variable of interest is whether or not a grandmother has ever lived in the same household as the child during his/her first nine years of life. Three dichotomous variables were created: ever coresided by age 3, ever coresided by age 5, and ever coresided by age 9. Another predictor variable estimates the duration of grandmother coresidence ranging from zero to nine years.

Child characteristics. Child gender, age in months, and low birth weight status are held constant in the analysis. First-born children are identified by a dummy variable in the model to account for new parents who might be more inclined to rely on grandmothers for support.

Mother characteristics. Mother's race was specified as non-Hispanic White, non-Hispanic Black, and Hispanic based on mother's self-report. To further capture cultural influences, mother's immigrant status is defined as foreign-born or not. Mother's age at first birth is included to tease out young first-time mothers who may have previously, if not at the time of measurement, selected into coresidence in need of grandmother's help. Mother's relationship status with the baby's father for years three, five, and nine is also held constant.

Socioeconomic factors include mothers' educational attainment, employment status, and receipt of Supplemental Nutrition Program for Women Infants and Children (WIC) benefits. Income-to-needs ratios were calculated based upon family size and household income, with 1 or less indicating poverty (Sebelius, 2011). A food insecurity scale was also used to create an indicator variable of financial strain that caused hunger or compromised nutritional intake in the household. Mothers were asked 15 questions about how money affected the frequency, size, and nutritional quality of their family's meals. If they answered yes to at least three of the 15 questions their household was classified as "food insecure" (Bendheim-Thoman Center for Research on Child Wellbeing, 2008; Kimbro et al., 2007). This measure was only available for the third and fifth-year interviews.

Maternal health status and health behaviors that influence child health (i.e. genetic influence, modeling poor diet and low activity, etc.) are accounted for with mother's weight status, in addition to whether or not she smoked during pregnancy, a predictor of persistent unhealthy weight for the offspring (Oken, Levitan, & Gillman, 2008), and duration of breastfeeding. The breastfeeding covariate is divided around a threshold of four months, a critical point at which nursing yields protective effects for childhood obesity (Burdette & Whitaker, 2007).

Mothers' emotional wellbeing is derived from 12 questions on a parental stress scale that assessed parents' feelings in various areas of life including sense of control and satisfaction ($\alpha = 0.77$). These questions were drawn from the Early Head Start Study in addition to some that were created for the Fragile Families study. Responses were made on a likert scale

ranging from 1 (strongly agree) to 5 (strongly disagree). Once the questions were summed from zero to 12, mothers were coded as highly stressed if they ranked one standard deviation above the mean.

Parenting Practices. Parenting variables attempt to measure the extent of sedentary behavior, physical activity, and cognitive stimulation in which the child is engaged at age 3. These include allowing a child to take a bottle to bed, the number of hours a child watches television per day, and the number of public outings (i.e. to the zoo, museum, etc.) a child is taken on per week. The most regular child care arrangement is also included.

Child's lifestyle. Measures similar to those described in parenting practices were included in year-five models to illustrate a more age-appropriate picture of children's lifestyle. The total number of hours per week children spent away from home in school/structured care and the number of hours playing outdoors on a typical weekday and weekend day are measured as a continuous variable, while the number of hours children spent doing sedentary activities (e.g., watching TV, playing video games, using computer, etc.) on a typical weekday and weekend day was trichotomized (i.e., 0-1 hour, 2-4 hours, or ≥ 5 hours).

Built environment. Controls for access to food are seen as proxies for family diet. Respondents were asked to identify their most common sources of food shopping, such as a grocery store/supermarket or smaller store (e.g., corner store, convenience store, or bodega). Limited access to grocery stores was also operationalized as a dummy variable for usual mode of

transportation to do food shopping (Kimbrow et al., 2007).

Analytic Plan

Bivariate analysis of the dependent and independent variables and the universal grandmother coresidence predictor was conducted using t-tests and chi-square tests whenever appropriate. Multivariate analyses for weight outcomes at 3 years of age included six models of covariates that are associated with childhood obesity and/or grandmother coresidence, whereas the analyses for age 5- and 9-year outcomes included five and four models of covariates respectively. (Fewer models in subsequent years reflected the variables measured and/or availability of data in these waves.) The literature, reviewed above, guided how covariates were grouped into models, in addition to previous work with this dataset (Kimbrow et al., 2007). Logistic regression was used to determine the influence of grandmother coresidence on childhood weight status with “overweight or obese” as the dependent variable. Children who have never resided with their grandmother comprised the reference group for the “ever coresided with grandmother” predictor. Logistic regression examined the effect of duration of grandmothers’ coresidence as a continuous variable on child weight status. Logistic regression was also used to test the year in a child’s life during which coresidence occurred (i.e., 1st year, 2nd year, 3rd year, etc.). These timing predictors are compared to other children who have never experienced coresidence. Analyses were performed using STATA 10.

Results

Descriptive Statistics

Characteristics of the sample are presented in Table 1. Half of the sample (n=1,824) were “coresiders,” or children who lived with their grandmother for some time during their first nine years of life, for a little under one year on average. Though most children in the total sample (63%) had a healthy weight, 37% were overweight or obese by three years old. By nine-years old the proportion of overweight or obese rose to 43% of all children. Half of coresiders (n=912) were first-born children. Most coresiding mothers were Black (55%) or Hispanic (29%). Sixty percent of coresiding mothers were single parents, which ultimately increased to 74% by age nine. On average, coresiding mothers were 20-years-old at their first birth, had less than a high school education when the child was born, lived in poverty, and received WIC during the baby’s first year.

Attrition analysis shows slightly more Hispanic ethnicity, marriage, and college education with substantially less WIC participation among mothers who identified as “other” ethnicities or were missing child weight status and/or coresidence information. The resulting sample with valid data, therefore, appears to represent lower socioeconomic status, which corresponds with the Fragile Family Study’s intended sample design (Reichman et al., 2001b).

Table 1

*Descriptive Statistics for Fragile Families Study 2:
Variables by Grandmother Residence*

Resident	Total Sample	Ever Resident	Never
	Grandmother	Grandmother	
	%, M (SD)	%, M (SD)	%, M (SD)
<i>Grandmother Coresidence</i>		50	50

Number of Yrs Lived w/ grandmother	--	0.78 (1.49)	--
<i>Child's Weight Status</i>			
Healthy weight, 3yrs	63	61	64
Overweight, 3yrs	18	18	18
Obese, 3yrs	19	21	18
<u>Overweight/Obese, 3yrs</u>	<u>37</u>	<u>39</u>	<u>36</u>
Healthy weight, 5yrs	64	63+	65
Overweight, 5yrs	18	18	18
Obese, 5yrs	18	19	16
<u>Overweight/Obese, 5yrs</u>	<u>36</u>	<u>37</u>	<u>34</u>
Healthy weight, 9yrs	57	56	58
Overweight, 9yrs	17	16	18
Obese, 9yrs	26	28*	24
<u>Overweight/Obese, 9yrs</u>	<u>43</u>	<u>44</u>	<u>42</u>
<i>Child's Characteristics</i>			
Child is a boy	52	53	52
Low birthweight	10	11+	9
First born	38	50***	30
<i>Mother's Background Characteristics</i>			
(White)	22	16***	29
Black	50	55	48
Hispanic	28	29	23
Immigrant	17	13	14
Age at first birth	21. (5.24)	20.30*** (4.23)	22.43 (5.68)
(Nonresident baby's father, 3yrs)	46	60***	37
Cohabing w/ baby's father, 3yrs	22	22	21
<u>Married to baby's father, 3yrs</u>	<u>32</u>	<u>18</u>	<u>42</u>
(Nonresident baby's father, 5yr)	55	68***	45
Cohabing w/ baby's father, 5yr	14	25	14
<u>Married to baby's father, 5yr</u>	<u>31</u>	<u>18</u>	<u>41</u>
(Nonresident baby's father, 9yr)	62	74***	52
Cohabing w/ baby's father, 9yr	9	9	9
<u>Married to baby's father, 9yr</u>	<u>29</u>	<u>17</u>	<u>39</u>
<i>Mother's SES %</i>			
Less than high school, birth	35	41***	27
(Completed high school/GED, birth)	30	32	30
Some college, birth	24	22	27
<u>College or beyond, birth</u>	<u>11</u>	<u>5</u>	<u>16</u>
Less than high school, 9yr	22	25***	18
(Completed high school/GED, 9yr)	21	22	20
Some college, 9yr	41	43	41
<u>College or beyond, 9yr</u>	<u>16</u>	<u>10</u>	<u>21</u>
Mother is employed, 3yr	56	55**	60

Mother is employed, 5yr	59	58*	62
Mother is employed, 9yr	62	61*	64
Poor, 3yr	42	48***	36
Poor, 5 yr	41	47***	36
Poor, 9yr	37	42***	33
Food Insecurity, 3yr	17	17	16
Food Insecurity, 5yr	15	15	15
Participated in WIC at yr 1 ^a	73	81***	68
<i>Mother's Health & Health Behaviors</i>			
(Healthy weight, 3yr)	31	31	31
Overweight, 3yr	27	26	27
Obese, 3yr	42	43	42
(Healthy weight, 5yr)	28	29+	26
Overweight, 5yr	29	27	31
Obese, 5yr	43	44	43
(Healthy weight, 9yr)	63	61***	38
Overweight, 9yr	13	12	22
Obese, 9yr	24	27	40
High stress level, 3yr	17	17	16
High stress level, 5yr	14	14	14
Smoked during pregnancy	20	21**	17
(Never breastfed)	43	48***	39
Breastfed < 4 months	29	30	29
Breastfed ≥ 4 months	28	22	32
<i>Parenting Characteristics, 3yr</i>			
Takes bottle to bed	7	7	7
(At-home care by parent)	41	37**	42
In-home childcare	30	35	29
Center-based childcare	29	28	29
(Child watches TV 0-1 hrs/day)	20	17***	24
Child watches TV 2-4 hrs/day	59	60	58
Child watches TV ≥ 5 hrs/day	21	23	18
(Child takes 0 public outings/wk)	39	40	37
Child takes 1-2 public outings/wk	52	51	53
Child takes ≥ 3 public outings/wk	9	9	10
<i>Child Lifestyle, 5yr</i>			
Hrs/wk in school or childcare center	29.16 (11.97)	30.44 *** (11.37)	28.06 (12.34)
(Sedentary activity 0-1 hrs/wkday	20	17***	24
Sedentary activity 2-4 hrs/wkday	57	56	56
Sedentary activity ≥ 5 hrs/wkday	23	27	20
(Sedentary activity 0-1 hrs/wkend	13	11**	14
Sedentary activity 2-4 hrs/wkend	42	38	45
Sedentary activity ≥ 5 hrs/wkend	45	51	41
Hrs of outdoor play/wk day	2.05 (1.90)	2.13*** (2.02)	2.06 (1.86)
Hrs of outdoor play/wkend day	3.24 (2.40)	3.36 (2.55)***	3.22 (2.30)

Built Environment, 3yr

Doesn't shop at grocery	5	4	4
Walks/taxi/bus to shop at grocery	28	31***	22
N	3652	1824	1828

¹+ p<.10; *p<.05; **p<.01; ***p<.001 from chi-square or t-tests for differences between Ever Lived w/Grandmother and Never Lived w/Grandmother (two-tailed tests); Parentheses indicate reference category

^aWIC = Special Supplemental Nutrition Program for Women, Infants, and Children

Multivariate Analyses

Logistic regression analyses revealed an increased risk of childhood overweight and obesity in homes where grandmothers reside. Table 2 presents odds ratios for whether or not a child had ever lived with a grandmother by age three, regressed on overweight and obesity in three-year-old children. Children from multigenerational homes were more likely to be overweight or obese than those who never lived with a grandmother after adjusting for all covariates (1.47, p<0.01). Covariates in models 2-6 were linked with overweight/obesity at age 3 as expected. Notably, none of the factors that demonstrated an association with child weight status diminished the link between grandmother coresidence and child weight status at age three.

Table 2***Logistic Regression of Overweight & Obesity in 3 year-olds by Grandmother Coresidence***

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
GM Coresidence by 3yrs	1.225*	1.267*	1.331**	1.414*	1.439**	1.467**
	(0.111)	(0.120)	(0.142)	(0.190)	(0.198)	(0.202)

Child Characteristics					
Male	0.922 (0.0825)	0.919 (0.0864)	0.935 (0.112)	0.939 (0.116)	0.950 (0.118)
Child age in months	1.042* (0.0194)	1.045* (0.0210)	0.998 (0.0317)	0.995 (0.0318)	0.997 (0.0322)
Low birthweight	0.618** (0.105)	0.711* (0.122)	0.701 (0.162)	0.684 (0.159)	0.684 (0.158)
First born	0.936 (0.0890)	0.829+ (0.0871)	0.932 (0.127)	0.949 (0.133)	0.946 (0.133)
Mother Characteristics					
<i>Background Characteristics</i>					
Black		0.956 (0.134)	0.785 (0.138)	0.817 (0.151)	0.811 (0.151)
Hispanic		1.819** (0.290)	1.763** (0.353)	1.780** (0.366)	1.804** (0.373)
Immigrant		1.115 (0.187)	0.820 (0.194)	0.694 (0.168)	0.645+ (0.159)
Age at first birth		1.006 (0.0124)	1.004 (0.0162)	0.999 (0.0163)	0.999 (0.0164)
Cohab w/baby's father		1.030 (0.115)	0.954 (0.136)	0.917 (0.134)	0.916 (0.134)
Married to baby's father		0.844 (0.132)	0.753 (0.157)	0.734 (0.155)	0.741 (0.157)
<i>Socioeconomic Status</i>					
Less than HS education		0.990 (0.119)	0.885 (0.136)	0.870 (0.138)	0.868 (0.138)
Some college education		1.005 (0.134)	0.952 (0.161)	0.963 (0.165)	0.980 (0.168)
College and beyond		1.021 (0.231)	1.061 (0.292)	0.969 (0.281)	0.983 (0.288)
Working		1.215+ (0.123)	1.361* (0.177)	1.590** (0.236)	1.609** (0.239)
Poor		0.894 (0.101)	0.983 (0.142)	0.975 (0.144)	0.966 (0.145)

Food Insecurity	1.053 (0.132)	1.030 (0.168)	1.018 (0.168)	1.009 (0.167)
WIC participation	0.803+ (0.102)	0.723* (0.115)	0.719* (0.117)	0.724* (0.119)
<i>Health & Health Behaviors</i>				
Mom overweight		1.268 (0.211)	1.299 (0.221)	1.303 (0.223)
Mom obese		1.803** (0.274)	1.805** (0.282)	1.789** (0.281)
High stress level		1.184 (0.200)	1.250 (0.216)	1.262 (0.219)
Smoked during pregnancy		0.916 (0.149)	0.924 (0.152)	0.922 (0.152)
breastfed < 4months		1.121 (0.170)	1.133 (0.174)	1.132 (0.175)
breastfed > 4months		1.151 (0.184)	1.157 (0.192)	1.157 (0.193)
Parenting Characteristics				
Child takes bottle to bed		2.777** (0.667)	2.745** (0.667)	
In-Home childcare		0.769 (0.128)	0.775 (0.130)	
Center-based childcare		0.774 (0.130)	0.772 (0.130)	
Child watches TV2-4 hrs/day		0.965 (0.153)	0.952 (0.151)	
Child watches TV >5 hrs/day		0.795 (0.159)	0.782 (0.157)	
Child takes 1-2 outings/wk		1.130 (0.152)	1.144 (0.154)	
Child takes>3 outings/wk		0.952	0.991	

					(0.208)	(0.217)
Built Environment						
Doesn't shop at grocery store						1.935+
						(0.674)
Walks/Taxi/Bus to grocery shop						1.041
						(0.162)
Observations	2,235	2,163	2,021	1,332	1,304	1,301
Pseudo R-squared	0.0300	0.0932	0.0859	0.465	0.586	0.524

Note. Odds ratios are presented. Standard errors are in parentheses. WIC = Special Supplemental Nutrition Program for Women, Infants and Children. + $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Grandmother coresidence during the first three years demonstrated limited long-term associations with child's overweight and obesity status at ages five and nine. Models 2 and 3 in Table 3 show an increased likelihood of overweight or obesity at age five if the child ever lived with a grandmother by age three. These models highlight the same child and mother characteristics that were emphasized in the first regression, including lower odds for low birthweight, first born, and poverty, but higher odds among Hispanic children. As for overweight and obesity at age nine, only one model in Table 4 exhibits a significant link to coresidence by age three. Controlling for child characteristics yielded a modest increase in the likelihood of unhealthy weight at nine years old that approaches statistical significance (1.16, $p < 0.10$). Unlike previous models, boys showed decreased odds for being overweight or obese at age nine ($p < 0.05$).

Table 3

*Logistic Regression of Overweight & Obesity in 5 year-olds
on Grandmother Coresidence by Age 3*

	Model 1	Model 2	Model 3	Model 4	Model 5
Grandmother Coresidence by 5yrs	1.141 (0.110)	1.186+ (0.120)	1.250* (0.139)	1.157 (0.155)	1.043 (0.162)
Child Characteristics					
Male		0.924 (0.0874)	0.932 (0.0918)	0.988 (0.118)	0.871 (0.121)
Child age in months		1.007 (0.0199)	0.991 (0.0205)	1.004 (0.0252)	1.012 (0.0302)
Low birthweight		0.702* (0.121)	0.736+ (0.130)	1.029 (0.227)	1.071 (0.272)
First born		0.873 (0.0884)	0.807+ (0.0887)	0.814 (0.110)	0.751+ (0.116)
Mother Characteristics					
<i>Background Characteristics</i>					
Black			1.009 (0.144)	0.837 (0.148)	0.844 (0.187)
Hispanic			1.346+ (0.221)	1.322 (0.263)	1.221 (0.293)
Immigrant			1.282 (0.234)	1.261 (0.283)	1.215 (0.323)
Age at first birth			1.014 (0.0131)	1.014 (0.0157)	1.012 (0.0175)
Cohab w/baby's father			0.976 (0.142)	0.867 (0.151)	0.800 (0.167)
Married to baby's father			0.861 (0.117)	0.680* (0.113)	0.661* (0.128)

Socioeconomic Status

Less than HS education	1.024 (0.128)	1.002 (0.155)	0.929 (0.172)
Some college education	0.952 (0.130)	0.782 (0.129)	0.760 (0.141)
College and beyond	0.753 (0.176)	0.728 (0.207)	0.833 (0.257)
Working	1.065 (0.114)	1.031 (0.133)	1.053 (0.163)
Poor	0.779* (0.0917)	0.713* (0.102)	0.762 (0.128)
Food Insecurity	1.173 (0.161)	1.246 (0.206)	1.275 (0.246)

Health & Health Behaviors

Mom overweight		1.356+ (0.230)	1.309 (0.260)
Mom obese		2.712** (0.421)	2.893** (0.525)
High stress level		0.729+ (0.134)	0.669+ (0.149)
Smoked during pregnancy		1.031 (0.163)	1.017 (0.191)
Breastfed < 4months		1.171 (0.176)	1.243 (0.215)
Breastfed > 4months		1.245 (0.203)	1.209 (0.228)

Child's Lifestyle

Hrs in school or center/wk		1.002 (0.00614)
Sedentary 2-4hrs/weekday		0.982 (0.184)
Sedentary >5hrs/weekday		1.041 (0.255)
Sedentary 2-4hrs/weekend		1.065 (0.244)

Sedentary > 5hrs weekend	1.400 (0.339)
Hrs of outdoor play/ weekday	0.995 (0.0494)
Hours of outdoor play weekend	1.045 (0.0390)

Observations	2,004	1,947	1,825	1,357	1,021
Pseudo R-Squared	0.0310	0.482	1.030	0.343	0.215

Note. Odds ratios are presented. Standard errors are in parentheses. WIC = Special Supplemental Nutrition Program for Women, Infants and Children. + p<.10; *p<.05; **p<.01; ***p<.001.

Table 4

Logistic Regression of Overweight & Obesity in 9 year-olds on Grandmother Coresidence by Age 3

	Model 1	Model 2	Model 3	Model 4
Grandmother Coresidence by 3yrs	0.12 (0.076)	1.156+ (0.0933)	1.125 (0.101)	1.167 (0.136)
Child Characteristics				
Male		0.829* (0.0628)	0.802** (0.0638)	0.853 (0.0893)
Child age in months		1.011 (0.00885)	1.005 (0.00956)	1.020 (0.0143)
Low birthweight		0.734* (0.0983)	0.712* (0.0983)	0.817 (0.145)
First born		0.938 (0.0751)	0.896 (0.0792)	0.821+ (0.0962)
Mother Characteristics				
<i>Background Characteristics</i>				

Black	1.477**	1.207
	(0.167)	(0.183)
Hispanic	1.556**	1.440*
	(0.208)	(0.260)
Immigrant	1.148	1.306
	(0.166)	(0.271)
Age at first birth	1.019*	1.030*
	(0.00966)	(0.0132)
Cohab w/baby's father	1.251	1.282
	(0.178)	(0.227)
Married to baby's father	0.861	0.775+
	(0.0896)	(0.109)
<i>Socioeconomic Status</i>		
Less than high school education	0.831	0.899
	(0.105)	(0.147)
Some college education	0.738**	0.776+
	(0.0784)	(0.109)
College or beyond	0.509**	0.593**
	(0.0754)	(0.116)
Working	1.042	1.073
	(0.0915)	(0.123)
Poor	0.827*	0.805+
	(0.0783)	(0.0986)
<i>Health & Health Behaviors</i>		
Mom overweight		1.383*
		(0.202)
Mom obese		2.074**
		(0.262)
Smoked during pregnancy		1.000
		(0.139)
Breastfed < 4 months		0.982
		(0.128)
Breastfed > 4 months		0.807
		(0.112)
Observations	3,050	2,859
		2,657
		1,595

Pseudo R-Squared	0.046	0.249	0.388	0.0628
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Note. Odds ratios are presented. Standard errors are in parentheses. WIC = Special Supplemental Nutrition Program for Women, Infants and Children. + $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$.

Having ever coresided with a grandmother by age five had almost the exact same association with unhealthy weight at 9 years old as the age three predictor (data not shown). Odds slightly increased for overweight and obesity at age nine (1.16, $p < 0.10$) only when controlling for child characteristics. There was no evidence of unhealthy weight at age nine for children who lived with their grandmothers at nine years old.

A dosage effect was also tested, in which the total number of years a grandmother has lived in the household was regressed on overweight and obesity for each child (data not shown). A dosage effect up to year three is revealed with the same regression models 1 through 6 as those in presented in Table 2. Results indicate that every additional year of grandmother coresidence up to age three was associated with increased odds of child overweight and obesity at three years old with full adjustments (1.13, $p < 0.05$). Other associations with covariates were similar to the series of regressions in Table 2. Again, the dosage association is not explained by any of the covariates and remains significant in the full model. A dosage effect was not found for grandmother coresidence through nine years.

Developmental timing, or the year in a child's life during which coresidence occurred, was also explored (data not shown). Coresidence at each wave up to age three was tested because previous models indicate these first three waves as most predictive. Findings show that coresiding with a grandmother during the first year of life was linked to increased odds (1.35, $p < 0.05$) of becoming overweight or obese at three years old compared children who

experienced coresidence in other years when child and mother's background characteristics are held constant.

Discussion

The results from the present study illustrate the importance of considering the extended family system within a bio-ecological model when investigating the phenomenon of early childhood obesity. Findings indicate that disadvantaged young children in America who have ever lived with a grandmother are at a substantially increased risk of obesity at age three, an association that has not been found in the literature to date. Grandmother's presence during the first year of life is particularly associated with overweight children at age three compared to other children who experienced coresidence with grandmothers. The longer a child lives with a grandmother, the greater the likelihood of an unhealthy weight status at three years old. These associations diminish by age nine, which suggests that the timing and sequence of contextual experiences may only affect the development of obesity in very early childhood.

These findings support other research that notes recent changes in normative growth trajectories among young children (Rolland-Cachera, Deheeger, Maillot, & Bellisle, 2006). Typically after the first year, BMI decreases until ages 5 to 7, at which point it begins to increase again. Adiposity rebound refers to the period where BMI increases after reaching its lowest point. Studies show earlier adiposity rebound, between ages 3 and 6, is occurring more often and is a strong predictor of overweight in adulthood (Rolland-Cachera et al., 2006). Grandmother coresidence may not only contribute to the premature occurrence of adiposity rebound, but may also reduce the nadir of their growth curve. In other words, children in multigenerational homes may not become as lean as they should before their BMI begins to increase.

This phenomenon further emphasizes a discrete and unique time period early in life that is critical for shaping lifelong health trajectories.

Notably, the link between grandmother coresidence and child unhealthy weight at age three was robust to characteristics of the child, mother, parenting, and built environment in the logistic regression. Though none of these factors explained the link between grandmother coresidence and child weight, many of the findings align with existing obesity research.

What could be driving this grandmother association? Selection into multigenerational households is one plausible explanation. In this sample, mothers living with grandmothers appear to be more vulnerable as they tend to be new mothers, younger, Black, single, less educated, poor, or eligible for public aid; all of which are risk factors for unhealthy child weight status. Perhaps these characteristics also demonstrate more need for grandmothers' assistance. Inexperienced young, less educated, or first-time mothers may not know how to provide a healthy start for their child's life (Aubel, 2011; Xie et al., 2003), and thus, rely on grandmothers parenting knowledge. Poor mothers seeking financial stability may decide to live with grandmothers for financial support (Simmons & O'Neill, 2001; Wightman, Patrick, Schoeni, & Schulenberg, 2013), or may be limited to inexpensive low-nutrient foods for their family (Drewnowski & Eichelsdoerfer, 2010; Dubois et al., 2006). Both Black and single mothers tend to turn to grandmothers for parenting assistance (Cohen & Casper, 2002; Luo, LaPierre, Hughes, & Waite, 2012), but there is also evidence of increased obesity in their children (Huffman, Kanikireddy, & Patel, 2010). Although these markers of vulnerability were controlled for in all analytic models, there may also be unmeasured variables associated with grandmother coresidence that are operating.

One such unmeasured aspect of vulnerability is conflict. Extended households likely involve a diffusion of responsibility that can give rise to a power struggle between the mother and grandmother, leading to conflict (Chase-Lansdale, Gordon, Coley, Wakschlag, & Brooks-Gunn, 1999; Glassman, Figueroa, & Irigoyen, 2011). Such discord may involve disagreement and/or miscommunication about appropriate feeding methods (Glassman et al., 2011), which could potentially lead to overfeeding and might foster unhealthy food associations for the child. Moreover, the presence of conflict in and of itself may create a stressful environment for children, which in turn, can affect their eating habits and the way their bodies process food. Studies show that social stress can ultimately result in insulin resistance and central obesity through activation of the sympathoadrenal system (Innes, Vincent, & Taylor, 2007; Li, Li, Zhou, & Messina, 2013; Seematter, Binnert, & Tappy, 2005).

Other family process theories specific to parenting could be at work in multigenerational households. Because parenting is critical for shaping children's food preferences and their ability to self-regulate food intake (Benton, 2004; Birch & Fisher, 1998; Patrick, Nicklas, Hughes, & Morales, 2005; Scaglioni et al., 2011), poor parenting could be a potential pathway. Both mothers' and grandmothers' exhibit less positive parenting skills and knowledge in situations of prolonged coresidence (Chase-Lansdale et al., 1999; Gordon, Chase-Lansdale, & Brooks-Gunn, 2004; Scaramella, Neppl, Ontai, & Conger, 2008; Wakschlag, Chase-Lansdale, & Brooks-Gunn, 1996). Mothers who lack parenting skills might not learn how to respond appropriately to infants' cues of hunger or satiety or might rely on food as a parenting tool to placate a crying child for lack of an alternative solution through toddlerhood. Further research should measure parenting capacity and practice in three-generation homes to explore this theory.

One could also speculate about generational mechanisms that foster overweight and obesity in young children. Grandparents are infamous for “spoiling” grandchildren (Cherlin & Furstenberg, 1986; Fuller-Thomson, Serbinski, & McCormack, 2014; Ross, Hill, Sweeting, & Cunningham-Burley, 2005). There is a common tendency for grandparents to indulge their grandchildren in the pleasures of life, which includes food. Grandmothers who ascribe to the American tradition of spoiling kids, may feed their grandbabies too often or introduce solids or unhealthy foods too soon. Furthermore, feeding babies is a natural and common way of bonding with a young child. Therefore, it is reasonable to assume that more women in the household with the desire to nurture a baby may result in over feeding the child as well.

Healthy feeding standards have also changed from generation to generation (Barnes, 1987; Davis & Saltos, 1999). Consequently, grandmothers may not be aware of current doctor recommendations or may simply disagree with them in favor of “old school” customs. Such an association could indicate that supplementation is occurring. Older generations might also consider heavier babies healthier. In terms of physical activity, grandmothers could simply be physically unable to be active with young children. Engaging in more sedentary activities with the grandmother may foster an inactive lifestyle that can lead to children’s unhealthy weight status. Future work should explore potential generational factors existing in extended households that may influence overweight and obesity during early childhood.

These proposed mechanisms may explain the short-term grandmother effect, but does not clarify why grandmother’s influence on child weight status fades over time. One simple reason may be that most coresident grandmothers in this sample moved out of their grandchild’s household in later waves. Of those

grandmothers who coresided with their grandchild at some point during the first three years, only 23% and 14% remained in the household by ages 5 and 9 respectively.

Another possibility to consider is that the potential mechanisms that caused a short-term effect (e.g. conflict, poor parenting, etc.) may improve over time. Perhaps mothers who were initially less confident in their parenting, gain confidence with every year of practice or learn how to co-parent more effectively. Interestingly, the proportion of obese mothers in multigenerational households declines by age 9 compared to those who did not live with a grandparent (Table 1), suggesting that the family could be becoming healthier also.

Characteristics of the distinct developmental periods measured may give insight into why grandmother influence wanes. Preschool-age and school-age are qualitatively different developmental stages that may implicate grandmothers' involvement in different ways. When children begin school, they become more exposed to different contexts. Influences outside the home including peers and teachers (Davison & Birch, 2001b; Ross et al., 2005) may compete with grandmothers' influence. As both the child and the grandmother grow older, they may become generationally disconnected from one another. The nature of their relationship may change by spending less time together or just spending time differently. For instance, if grandmothers connected with young children by feeding them, this may not be as appealing or enjoyable for five and nine year olds.

Limitations

Future research should also address the limitations of this study. There is no distinction between grandmother-headed and mother-headed households nor who is the primary caregiver in this sample, which has implications for power dynamics and conflict in parenting (Bachman &

Chase-Lansdale, 2005; Glassman et al., 2011). Measures on family roles and daily routines with a particular focus on eating behaviors and physical activity are necessary to better understand the association. Future work should include family interrelationship, co-parenting, and time-use data before and after birth that test some of the explanations proposed above and may also elucidate selection into extended family households.

Causal claims cannot be made until endogeneity is addressed to capture potential bias from correlated variables unobserved here. Families may sort into different living arrangements based on characteristics that are also associated with raising an overweight or obese three year old. Fixed-effects analyses is one way of testing this, but may not be suitable for this sample given limited variation in child weight status across waves. Fifty-eight percent of those who have complete data for weight in ages 3, 5, and 9 exhibit stable weight over time, which can make selection findings undetectable through fixed effects. Future studies should explore other methodologies that would account for this sample characteristic.

Conclusion

The present study extends knowledge in the field by identifying grandmother coresidence as a risk factor for overweight and obesity in young disadvantaged children. Because unhealthy weight early in life is predictive of unhealthy weight later in life (Janssen et al., 2005; Nader et al., 2006; Singh et al., 2008), these findings are theoretically important to understand the nature of the problem and practically relevant for prevention. This study suggests that prevention efforts should identify multigenerational households as at risk for early childhood obesity and employ family-based approaches that pay particular attention to practices within disadvantaged families. Family-based obesity prevention and weight

management programs could be more beneficial for young children in multigenerational homes if they include coresident grandmothers in their framework. Healthcare providers who use patient-centered approaches should be sensitive to the influence of extended kin, culture, and feeding routines on child weight status. More study is needed to better understand the mechanisms at work in order to craft effective prevention and intervention strategies. An even more thorough application of a multi-contextual model that nests the family within larger extrafamilial systems (i.e. including communities, institutions, and culture) may elucidate interconnections among various levels of context that may facilitate the occurrence of obesity among young children in three-generation family structures.

Acknowledgements: The author wishes to thank Dr. P. Lindsay Chase-Lansdale, Dr. Madeleine Shalowitz, Dr. Jelani Mandara, and Dr. Lauren Wakschlag for their helpful insight and support.

Correspondence: Chelsea O. McKinney, PhD, MPH
Research Manager, North Shore University Health System
Evanston, Ill cmckinney2@northshore.org.

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*Research Article***Using Kinship Navigators to Assess the Needs of Kinship Caregivers**

Suzanne Sutphin, PhD
University of South Carolina

Abstract

Kinship care is a viable alternative to foster care for many children, however, the proper supports and services must be in place for the families. This article describes a kinship navigator program for children and kin caregivers involved in Child Protective Services in-home treatment cases. The program was piloted over a three-year period to assess and address the service needs of kinship caregivers. Using the Family Needs Scale as a measurement tool, the results of the evaluation are provided along with a discussion of the need to support caregivers to provide the best outcomes for children in kinship care.

Keywords: kinship, grandparents, navigator programs

The Connecting for Kids: Kinship Navigator Program was a three-year demonstration program funded by the Administration for Children and Families as part of the 2008 Fostering Connections to Success and Increasing Adoptions Act. The program used kinship navigators to provide specialized service referral to kinship caregivers all of whom were caring for relative children who were a part of Child Protective Services in-home treatment cases. The child welfare agency contracted with kinship navigators, community support specialists, to assess the kinship caregivers for needed services and make the appropriate service referrals.

The kinship navigators were able to increase service identification for caregivers to help ensure that the child(ren) would remain with the kinship caregiver, instead of being placed in foster care, while the parents were participating in their treatment plan. The navigators were also able to alleviate some of the work of the social services caseworker, who was responsible for assessing and monitoring the family while they had an open Child Protective Services in-home treatment case. This article will present an overview of the process of using kinship navigators to work with the families and results of the evaluation of the program. The article will also provide information about the assessment of the families, services referred, services used, and satisfaction with the services received.

Literature Review

Many children are diverted from foster care into kinship placements (Annie E. Casey Foundation, 2013; Geen, 2004; Wallace & Lee, 2013). The kinship caregivers, therefore, are fictive and non-fictive kin who are responsible for the care of children when their birth parents, the biological adults responsible for them, can no longer care for the children. As discussed below, kinship caregivers have a unique set of needs, and it is important to examine the needs of these caregivers and provide access to the appropriate supports so that the kin for whom they are caring can remain safely in their home instead of going into foster care. The need for services for kinship caregivers is established in the literature along with the lack of available resources and the lack of use of available services.

Benefits of Kinship Care

There are significant benefits to placing children with relatives when their birth parents cannot care for them. In appropriate kinship placements, children can have

greater permanency and well-being compared to children in foster care (Metzger, 2008; Rubin, Downes, O'Reilly, Mekonnen, Luan, & Localio, 2008; Sakai, Lin, & Flores, 2011). For example, Zinn (2012) found that children placed with grandparents have low rates of placement disruption. Kinship caregivers usually live in close proximity to the children's biological parents and share the same sense of family and community. Also, with the proper supports, kin families are likely to be able to keep siblings together (Hegar & Rosenthal, 2009).

Children in kinship care often report a great attachment to the caregiver and the family (Hegar & Rosenthal, 2009). Children are usually familiar with the relative and are likely to have increased contact with their biological parents compared to being placed in foster care. They are also likely to experience greater stability and support in kinship care (Billing, Ehrle, & Kortenkamp, 2002; Dubowitz, Feigelman, Harrington, Starr, Zuravin, & Sawyer, 1994; Sakai et al., 2011; Winokur, Crawford, Longobardi, & Valentine, 2008).

Several studies have examined the outcomes of children in kinship care compared to those in foster care. In one study, the children in kinship care had "good or better outcomes" (Winokur et al., 2008, p. 344). Using data from the National Survey of Child and Adolescent Well-Being, Sakai, Lin, and Flores (2011) found that children in kinship care often have better behavioral outcomes compared to those in foster care. Children in kinship care have higher scores on expressive functions and are less at risk for delays in motor development and neurocognitive development compared to those placed in foster care (Stacks & Partridge, 2011). Infants have also shown the positive effects of kinship placements compared to foster care including decreased risk factors and a shorter time in the placement (Stacks & Partridge, 2011).

Service Needs for Kinship Caregivers

To maintain the children safely in the homes of kinship caregivers, many studies have identified the need to provide services to the caregivers. These needs have centered on the needs for financial resources, child care, legal services, and additional needs to support the family.

Financial Needs

Much of the identified needs for services for kinship caregivers has focused on the need for financial services (Chen, Hendrick, & Young, 2010; Coakley, Cuddeback, Buehler, & Cox, 2007; Landry-Meyer, 1999; Sakai et al., 2011). Many grandparents raising their grandchildren are low-income families and have a great need for financial resources (Ehrle, Geen, & Clark, 2001; Nelson, Gibson, & Bauer, 2010; Sakai et al., 2011; Sands & Goldberg-Glen, 2000). The lack of financial support increases the stress experienced by the grandparent (Dowdell, 1995; Sands & Goldberg-Glen, 2000). Kinship caregivers often do not use the financial resources available to them. In her study of kinship caregivers, for example, Dowdell (1995) found most of the caregivers in the study did not receive public financial assistance or food stamps even if they were eligible for the assistance.

Subsidized kinship care does not exist in many states (Nelson et al., 2010). The financial support offered by the state includes the Temporary Assistance for Needy Families (TANF) child-only welfare grant (Geen & Berrick, 2002), supplemental security income (SSI), (Ehrle & Geen, 2002; Ehrle et al., 2001; Murray, Macomber, & Geen, 2004) and social security for those who are eligible. TANF is part of a federal program created in 1996 to provide cash assistance to children and adults. Child-only TANF payments can be provided to children living in a home with no biological parent present, which make up the largest portion of the child-only TANF cases; however,

many eligible children are not enrolled and caregivers may not be aware of the child's eligibility (Mauldon, Speiglmann, Sogar, & Stagner, 2012). TANF payments vary by state and are usually less than a foster care payment (Ehrle et al., 2001). In their study of kinship caregivers, Gordon, McKinley, Satterfield, and Curtis (2003) found that many caregivers use the money saved for retirement to support the children in their care. These research findings point to the need to increase financial supports to safely maintain the children in the home and an increased awareness of the financial supports that are available.

Child Care Needs

Previous studies have identified the need for childcare in addition to the need for financial assistance (Berrick, Barth, & Needell, 1994; Gerard, Landry-Meyer, & Roe, 2006; Sakai et al., 2011). Childcare services are often excluded from the service array of supports provided by the state for kin caregivers (Ehrle & Geen, 2002). In an interview of kin caregivers, many identified a need for child care to continue working (Coakley et al., 2007). Providing access to this service can reduce stress for the caregivers, which can improve their overall well-being (Gerard et al., 2006).

Legal Needs

Kinship care presents legal issues and concerns for kinship caregivers (Gerard et al., 2006). In studies of kinship caregivers, many caregivers lacked information and did not understand the legal custody situation for the children in their care (Gordon et al., 2003). Kinship caregivers need help understanding the court process, especially if they or their grandchildren are needed to be present in court (Scannapieco & Hegar, 2002). Additionally, some kinship caregivers may decide to seek legal custody or guardianship of their grandchildren. These

caregivers often lack access to the appropriate legal services available (Scannapieco & Hegar, 2002; Wallace & Lee, 2013). The access to legal services can lend to a sense of security for the caregivers seeking to make the placement a more permanent living situation for their grandchildren (Gordon et al., 2003).

Other Needs

Research has identified other needs of caregivers. Coakley, Cuddeback, Buehler, and Cox (2007) point out that kin caregivers need an array of services including parenting skills as well as access to resources. In a qualitative study of African American grandmothers, Gibson (2005) found that the grandmothers identified a need for coping with emotional and behavioral problems associated with the children. Caregivers also identified a need for access to support groups (Gerard et al., 2006; Sakai et al., 2011) and training (Berrick et al., 1994). Other top needs include assistance with housing and food (Ehrle & Geen, 2002), recreational activities for the children and the family, counseling for the children, information about available services, and tutoring for the children (Landry-Meyer, 1999). It is evident that an array of services is needed to support kinship caregivers and the children in their homes.

Service Accessibility

As described above, children in kinship care and kinship families have a variety of service needs. However, many of the children and families do not receive services for which they are eligible (Ehrle & Geen, 2002; Ehrle et al., 2001). Kinship caregivers may experience barriers in accessing services. For example, in examining data from the National Longitudinal Study of Adolescent Health, Nelson, Gibson, and Bauer (2010) found that 87% of the kinship youth in the sample were eligible for a TANF child-only grant yet

they estimate that only 10% - 25% of these youth receive the grant. Gerard, Landry-Meyer, and Roe (2006) found that many grandparent caregivers did not use some of the supports available to them including kinship navigators, counseling services, and support groups.

There is a low usage of the state services because some kinship caregivers do not want to be involved with the child welfare agency (Murray et al., 2004; Schwartz, 2002). There is often a stigma attached to some of these services that prevent kin caregivers from accessing them despite the need (Ehrle & Geen, 2002; Ehrle et al., 2001). In their interviews of African American grandmother caregivers, Simpson and Lawrence-Webb (2009) found many grandmothers were confused and frustrated by the lack of resources available to them. The caregivers did not believe that the social services system was also able to refer them to resources to meet their needs. Caregivers also expressed a concern over placing the children in state custody and becoming licensed foster parents to receive the foster parent payment in that, ultimately, they feared losing their grandchildren (Simpson & Lawrence-Webb, 2009).

Kinship caregivers have indicated a lack of a feeling of respect from the child welfare agency, largely due to a lack of information provided. This leads to a situation of mistrust towards the agency. The caregivers sometimes feel as though they are being excluded from decisions made about the child. Many kinship caregivers feel the effects of high staff turnovers in the agency and have expressed a lack of service provision from the agency (Gordon et al., 2003). Kinship caregivers have also indicated issues navigating the service system and inadequate resources when needs were identified (Coakley et al., 2007). Being provided support services, however, enforces their role as a valued caregiver (Landry-Meyer, 1999).

While kin caregivers and foster parents provide the same service to the children in their care, they are not

provided the same resources. As pointed out by Scannapieco and Hegar (2002), child welfare workers may falsely assume that kinship caregivers do have as many needs as foster parents. Some eligibility workers may not be fully aware of services that are available to kin caregivers (Ehrle et al., 2001). Therefore, it is not surprising that kinship caregivers report having access to and using fewer services than foster parents (Berrick et al., 1994; Brooks, 2002; Brooks & Barth, 1998; Carpenter, Berman, Clyman, Moore, & Xu, 2004; Dubowitz, 1994). Kin caregivers have the option to become licensed foster parents to the kin children and then will receive foster care payments. Researchers propose that kinship caregivers should receive the same services provided to foster parents and that increased services could prevent entry into foster care and help support the entire family (Gordon et al., 2003; Schwartz, 2002).

Studies on kin caregivers and their use of services are often limited to those involved with child welfare system. Not all kin caregivers, however, are eligible for state-provided services (Ehrle & Geen, 2002; Ehrle et al., 2001). Informal caregiving arrangements often do not have the same access to needed services compared to those who have formal custody arrangements (Ehrle & Geen, 2002; Ehrle et al., 2001; Gerard et al., 2006). For example, children in public kinship care are more likely to receive services than those in private kinship care including financial assistance, food stamps, and Medicaid (Ehrle & Geen, 2002; Ehrle et al., 2001). Often kinship caregivers are unaware of the services for which they or the kin for whom they are caring are eligible (Ehrle & Geen, 2002; Ehrle et al., 2001; Gibson, 2003; Goelitz, 2007; Gordon et al., 2003; Langosch, 2012; Murray, Macomber, & Geen, 2004; Scannapieco & Hegar, 2002). Scannapieco and Hegar (2002) propose an array of services to kin caregivers

including financial, legal, mental health, medical, and dental services, social support and educational services.

Langosch (2012) describes that better policies need to be in place to provide the appropriate supports to kin caregivers. This includes more accessibility to available services for all kinship caregivers (Simpson & Lawrence-Webb, 2009). For example, in a pilot evaluation of caregiver supports, Chen, Hedrick, and Young (2010) identified the need to for a single place to help caregivers identify and access needed services. They also discovered a potential issue with limited service availability and inadequate services that do not fully address the needs of the caregivers. Results of the evaluation revealed that when caregivers did access needed services and resources, including financial supports, they had increased satisfaction in their role as a caregiver. This points to the need for kinship navigators (Sakai et al., 2011).

The Kinship Navigator Program

To address the issues discussed in the literature above including increasing awareness of and access to services, the Connecting for Kids Kinship Navigator Program was offered in six counties in a southeastern state. The eligible families were all a part of Child Protective Services in-home treatment cases (now referred to as family preservation cases). In these cases, the children were placed with kin while their parent(s) completed a treatment plan. The program was a partnership between the state child welfare agency, which had access to the target population, a provider agency, which contracted the kinship navigators, and a state university for training, evaluation, and media development. The program was intended to identify children in kinship care who may be at risk of entering foster care and provide supports in the form of service referrals to the kinship caregivers.

The counties involved in the program are situated regionally in the state. Three provider agencies were part of the project and contracted with the kinship navigators who were paid by the hour for their work with the families. The provider agencies each had a Navigator Coordinator who was responsible for overseeing the kinship navigators and reporting progress at monthly project meetings. As part of the program model, the provider agencies selected navigators who reflected the communities of the clients they served and communicated effectively with individuals from various backgrounds. All navigators were professionals and were knowledgeable of services available for kinship caregivers in their communities. Navigators were also tasked with providing targeted outreach to community partners to encourage their support of the program and of kinship caregivers. In this regard, they were to serve as community advocates for kinship caregivers by increasing awareness to community organizations.

In working with the families, the direct services offered by navigators included assessment for services, referrals for services, supportive listening, and referrals for specialized training. First, navigators assessed the potential needs of kinship caregivers and referred them to available services in their communities. During this time, the kinship navigators were able to refer the kinship caregivers to the specialized training that a contract agency developed for them as part of the project. Finally, while not an intended primary service, they provided supportive listening to help caregivers express any concerns they may be having about their new role.

Training for Navigators

The kinship navigators had access to a variety of training to help them in their role. The navigators participated in an initial training, which provided an overview of the project and their roles and responsibilities

as navigators. There was then a series of three webinars designed specifically for the navigators. The first two webinars included the overall process of the navigator model and the role of kin caregivers within the context of casework process and the specific duties that navigators would be expected to perform for each family. The third webinar focused exclusively on the evaluation including information about completing the evaluation instrument. Finally, a Kinship Navigator Practice Manual was developed to detail the process for the navigators and to provide resources to refer caregivers.

The Kinship Caregiver Referral Process

Eligible kinship caregivers were referred to the navigator program by their caseworkers. The caseworker described the navigator service to the caregiver to determine if he or she was interested in being referred. If the caregiver was interested in the service, the caseworker made the referral to the navigator program. To provide an overview of the program, kinship caregivers were directed to the program's website which included a presentation about the navigator program. A DVD and brochure were developed to serve as tools to help explain the benefits of the program. The caseworkers and navigators used these materials to work with the families and to help educate the community about the program.

If the caregiver was eligible and interested in receiving the service, the navigator contacted the family to continue to explain the service. If the caregiver declined the service at this time, he or she was referred to the United Way's 2-1-1 system for any potential needs. If the caregiver accepted the service, the navigator scheduled an in-person meeting.

The Role of the Navigator: Assessing the Needs of the Family

The primary focus of the program was to assess and refer for appropriate services. To assess the needs of the family, the navigators used the Family Needs Scale to identify needed service referrals. The Family Needs Scale is a 33-item scale that allows caregivers to rate their need for services on a 6-point rating scale (1 = never; 6 = always). At the initial assessment, the navigator completed the Family Needs Scale with the caregiver to assess needs and refer for services. The Family Needs Scale was re-administered once a month for up to three months, as long as the caregiver was still a part of the navigator program. Once areas of need were established by the assessment, the navigator identified appropriate referrals for services and helped the caregiver learn how to access the services. The service was offered for three months while the family was involved with Child Protective Services. When the service period concluded, the navigator made a final set of service referrals. The navigator then notified the caseworker of any remaining service needs the family may still have had.

This information became the basis of the data used in the evaluation. As part of the evaluation, the kinship navigators used a data collection form to capture demographic data, complete the Family Needs Scale, identify service referrals and usage, and track satisfaction with services used.

Results

The kinship navigators were able to collect demographic information on 370 caregivers. Of those who used the kinship navigator service, 55% were a grandparent with 54% of those being a maternal grandmother and 28% being the paternal grandmother. The average age of the caregiver was about 50 years old and the average age of the child in care was about six and half years old. Seventeen percent of the caregivers did not have a high school

diploma, and 35% made less than \$19,000 per year. Thirty-one percent of the children had been living with their relative from one to three months, and 24% had been living with the relative for nine months or more.

The overall results of the Family Needs Scale are provided below. The needs are listed in order from the greatest identified need. The top identified needs are shaded.

TABLE 1
Family Needs Scale

	<u>Initial</u> <u>Assessment</u>		<u>Follow-Up 1</u>		<u>Follow-Up 2</u>		<u>Follow-Up 3</u>	
	<i>n</i>	mean	<i>n</i>	mean	<i>n</i>	mean	<i>n</i>	mean
Extra money to buy necessities and pay bills	346	3.29	264	3.16	181	3.29	112	3.49
Info on where to get help	344	2.94	255	2.61	178	2.47	110	2.90
Help understanding government agencies	345	2.50	258	2.34	180	2.49	114	2.75
Time to do things for yourself	345	2.44	261	2.43	187	2.39	112	2.72
Someone to talk to about getting help for child	345	2.39	261	2.07	190	2.06	117	2.28
Help dealing with social services	343	2.36	258	2.25	180	2.33	111	2.43
Help getting/keeping public assistance	343	2.36	259	2.17	182	2.20	106	2.03
Support groups for kinship caregivers	343	2.20	259	1.94	187	1.89	112	1.99
Help getting enough food daily for two meals for your family	343	2.10	256	2.00	186	2.08	110	2.25
Someone to talk to about child (ren)	345	1.92	255	1.73	185	1.69	116	1.78
Routine child care	340	1.89	258	1.79	185	1.64	115	1.80
Time to do fun things with family	344	1.88	247	1.84	175	1.82	111	1.90

Respite care (someone to help care for my child when I need a break)	343	1.83	262	1.68	190	1.71	112	1.74
Mental health services for your child	343	1.74	254	1.72	184	1.76	114	2.00
Legal assistance (adoption/custody)	343	1.73	257	1.60	186	1.67	111	1.74
Medical care for your family	343	1.69	256	1.54	184	1.51	111	1.66
Help learning to be more effective parent	342	1.64	250	1.58	180	1.58	114	1.69
Dental care for family	342	1.58	253	1.49	185	1.44	109	1.54
School services for my child	341	1.52	257	1.44	187	1.43	113	1.54
To belong to parent groups or clubs	342	1.49	258	1.42	186	1.42	113	1.41
Help managing the daily needs of my child at home	341	1.49	260	1.43	188	1.38	115	1.45
Help transporting my child places, including appointments	344	1.47	259	1.43	187	1.44	112	1.52
Legal assistance related to benefits	339	1.45	252	1.41	178	1.35	108	1.35
Emergency child care	340	1.43	251	1.39	182	1.39	108	1.60
Help getting a job	340	1.43	255	1.39	184	1.35	112	1.51
Special education services for your child	341	1.38	255	1.35	185	1.32	114	1.46
Help enrolling my child in school	341	1.37	252	1.33	182	1.30	112	1.39
Assistance with alcohol and other substance abuse problems either for myself or family member	339	1.35	257	1.47	185	1.45	109	1.66
Emergency health care for your family	341	1.34	253	1.36	182	1.34	110	1.39
Help getting places you need to go for yourself	343	1.33	254	1.28	184	1.30	112	1.36

Help getting a place to live	339	1.32	254	1.30	177	1.32	115	1.32
Other legal assistance	339	1.24	250	1.21	179	1.28	110	1.43
Vocational training services for your child	339	1.09	243	1.12	174	1.15	112	1.19

From the Family Needs Scale, the main support needed to maintain stability was money to pay for bills and other necessities. Since many states do not offer additional subsidies for kinship families involved in with Child Protective Services, other than child-only TANF grants, this is a challenging service to offer based on the available community resources. In line with the previous research of Landry-Meyer (1999), other identified needs of the caregivers included: accessing public assistance, information on where to get help, help dealing with social services, help understanding government agencies, access to support groups, and counseling for children. Other needs addressed in the literature were not identified as top needs for caregivers included: access to transportation, childcare, and tutoring for the children.

Use of Services

The navigators also assessed the usage and satisfaction of services that the caregivers used. Over the three years of the project, 435 caregivers were referred to the kinship navigator program. Not all accepted the assistance of the navigators. Navigators indicated a total of 248 caregivers that were referred for services. Caregivers were largely referred for the following services: financial services, legal aid services, United Way, Angel Food Ministries, Department of Mental Health, HALOS. Available services were limited in many counties and the needs of the caregivers were largely the same, so we repeatedly saw the same services being referred. One hundred and seventy-nine referrals were made for support

services and 173 referrals were made specifically for financial services.

Supportive listening was also a service provided by the navigators, though not part of their main job duties. Caregivers could receive both supportive listening and service referrals from the navigators. The navigators responded that they provided supportive listening to 320 caregivers.

TABLE 2

Did the Caregiver Use the Service(s) for Which They Were Referred?

Responses	Frequency	Percent
Yes	117	52%
No	106	48%
Total	223	100%

Just over half (52%) of the caregivers who reported they were referred for a service indicated that they used the service. At the first follow-up with the caregivers, navigators indicated that 137 caregivers had used the service for which they were referred. This low service usage supports the research cited in several other studies (Berrick et al., 1994; Brooks, 2002; Brooks and Barth, 1998; Carpenter et al., 2004; Dubowitz, 1994).

TABLE 3

Caregiver Satisfaction with Services Used

Responses	Frequency	Percent
Very Unsatisfied	4	4%
Unsatisfied	5	5%
Somewhat Unsatisfied	3	3%
Somewhat Satisfied	19	19%
Satisfied	37	38%

Very Satisfied	31	31%
Total	99	100%

The majority of the caregivers, 88%, expressed satisfaction with the service they used.

Follow-up Survey with Caregivers

During the third year of the project, we conducted a follow-up survey with caregivers. One hundred and thirty surveys were mailed and we received responses from 17 caregivers, a 13% response rate. Caregivers who responded were given a gift card to Wal-Mart as an incentive for completing the survey. Despite the low response rate, the caregivers did provide important information regarding the kinship navigator program.

Eighty-eight percent indicated that the service time (three months) was long enough to meet their needs. Respondent indicated receiving referrals for medical services and food resources. Other main identified needs included clothing and baby items. One caregiver commented that monetary support would have been a helpful resource. There were several comments about the benefits of having a navigator. These comments included the navigator being accessible, listening, and providing information about resources.

Caregivers provided suggestions for improving the navigator program such as providing more financial resources, a faster contact time once custody is established, and to have the navigator be more active in making sure the resources are being used. One caregiver wrote, "I enjoyed being in the program; it helped me to see that there are others that are going through the same thing that I am facing now." Another commented, "This was a great service. Helped me with aid I knew nothing about."

Entry into Foster Care

One of the main outcomes of the project was to maintain the children in the home of the kinship caregiver while their parents were receiving treatment and thereby preventing their entry into foster care. Using state SACWIS data, the data collected by the Child Protective Services agency, the evaluator was able to track some of the children from the kinship navigator cases to determine if they had contact with the foster care system. Of the 75 cases that were tracked, seven (9%) had contact with foster care. The kin caregivers of all seven children had contact with the kinship navigator prior to the children having an open foster care date. The agency briefly placed one child in foster care one year after the family declined the service. Of those who entered foster care, most of the episodes were short – lasting only a few days to a few months. Two of the children are still in foster care, each having been in care about nine months. Overall, this data helps to demonstrate the benefits of supporting kinship caregivers as an alternative to foster care by preventing foster care entries.

Conclusions

The Connecting for Kids: Kinship Navigator Program was a demonstration project that illuminated the continued need to provide service referrals for kinship caregivers including knowledge of and access to services. As such the social services agency decided to incorporate the kinship navigator project into the standard service array and now has five regional kinship caregiver liaisons. Providing services for kinship caregivers has implications for state agencies and policymakers. Policymakers should continue to develop strategies to meet the needs of both kinship caregivers involved with the state child welfare agency and those who are not and identify which agencies are the most appropriate to provide services (Ehrle & Geen, 2002). Langosch (2012) advises that policy needs to change to

address the needs of kin caregivers by developing more comprehensive services for kin caregivers. Murray, Macomber, and Geen (2004) propose that states need to be aware of the eligibility of kinship caregivers for various services so they can continue to care for the children in their homes.

There were limitations to the evaluation. Based on the literature, which largely indicated higher needs for service referrals, the results from the Family Needs Scale were lower than anticipated. Many caregivers in the program had just assumed full-time care of their relative children. At that point at which they worked with the navigator, they may not have realized their full service needs. Also, the Family Needs Scale is quite long considering the time it would take to complete with caregivers, and, despite training, navigators may have not assessed all of the needs with the caregivers. This would lead to potentially underreporting service needs.

Kinship placements are often long-term placements for children. Therefore, many kin caregivers will have a long-term, ongoing need for services for their families. Coakley, Cuddeback, Buehler, and Cox (2007) revealed that kin caregivers are committed to keeping the family together, yet they experience many stressors in their new role. In their study of stressors for grandparents raising grandchildren, Sands and Goldberg-Glen (2000) found that 77% of those in their sample believed they would care for the children until the children reached adulthood. This further stresses the need to ensure that kinship caregivers have continued assessments for services and access to any service needs.

Using Kinship Care to Improve Outcomes

Important to all social services agencies are the concepts of safety, permanency, well-being, and family stability for children. The Kinship Navigator Program

demonstrated the need to support kin caregivers to help ensure that they are able to maintain these outcomes. Kinship caregivers desire to maintain their family system, and they seek to provide a safe and stable environment for the children. The caregivers also express a concern for the safety and well-being of the children in the home of the biological parents, who often are dealing with substance abuse issues (Gordon et al., 2003). Important to promote well-being, kin caregivers need access to financial and emotional supports (Scannapieco & Hegar, 2002). Safety, permanency, and well-being can be enhanced through proper service provisions and the use of kinship navigators.

Monetary support continues to be a need for kinship caregivers involved with Child Protective Services; however, grant services often exclude the dispersion of this resource. States need to find alternative ways to financially support these kinship caregivers. This will maintain children safely in the home and keep them out of foster care. This will also help to promote safety, permanency, and well-being and ensure that kinship families have the best possible outcomes.

Acknowledgement: Funding for this project was provided by a discretionary grant awarded to the South Carolina Department of Social Services by the Administration for Children and Families (Grant #: 90CF0017).

Correspondence: Dr. Suzanne Sutphin The Center for Child and Family Studies, The College of Social Work 226 Bull Street University of South Carolina, Columbia, SC 29208. Phone: (803) 777-8494
Email: sutphist@mailbox.sc.edu

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*Research Article***The Experience of Grandparents
Raising Grandchildren**

Deborah M. Sampson, M.S
Katherine Hertlein, PhD
Las Vegas, NV

Abstract

The purpose of this qualitative study was to understand the experiences of grandparents and the challenges they face raising their grandchildren. This study was conducted through qualitative interviewing, where participants responded to open-ended questions regarding the challenges of raising their grandchildren. Themes and patterns were identified through an open-coding process. The five themes discussed include: characteristics of everyday life, parenting experiences, lack of resources, managing negative emotions, and social changes. Implications for clinical practice and further research are discussed.

Keywords: grandparents, grandchildren, custodial grandparents

Background

According to the U.S. Census Bureau, in 1970, 2.2 million American children lived in a household maintained by a grandparent. By 1997, the number had risen to 3.9 million, a 76% increase over 27 years. An estimated 7.5 million children in the United States live in a household maintained by a grandparent (U.S. Census Bureau, 2010). The practice of grandparents rearing grandchildren is steadily rising.

Grandparents acknowledge several benefits when raising their grandchildren. These include a sense of purpose, a second chance in life, an opportunity to nurture family relationships, a chance to continue family histories, and receiving love and companionship (Langosch, 2012). Grandparents also benefit from giving and receiving love (Doblin-MacNab & Keiley, 2009), and perceiving themselves as more effective caregivers (Strom & Strom, 2011). In spite of the benefits, there are some real challenges. National studies of grandparent-headed families (GHF) in the United States indicate that such families are more economically disadvantaged (Brabazon, 2011) and have disproportionately high poverty rates, an economic variable strongly associated with poor health outcomes (Longoria, 2009). The economic demands of custodial grandparenting can cause problems with the already compromised health of grandparents as economic support from social service agencies is frequently unavailable or difficult to access. For example, 41% of GHF report having unmet service needs. In these instances, those not receiving services were younger and less likely to receive public assistance (Yancura, 2013).

These challenges also extend to one's physical health. Custodial grandparents describe more limitations in performing daily activities. Further, caregiving stress may result in exacerbation of health problems (Kelley, Whitley, & Campos, 2010; Williams, 2011). Studies cited frequent presence of multiple health problems such as hypertension and diabetes (Hadfield, 2014). Grandparents in GHF also reported feeling physically tired, having less privacy, and having less time with friends, family, and spouses (Hayslip & Kaminski, 2005).

The challenges faced by caregiving grandparents often influence their emotional and social health (Bundy-Fazioli, Fruhauf, & Miller, 2013). Research has consistently demonstrated that custodial grandparents have

high rates of depression (Song & Yan, 2012; Strutton, 2010), with married and older grandmothers experiencing less emotional strain than single or younger grandmothers (Conway, Jones, & Speakes-Lewis, 2011). Custodial grandparents seek health-services less frequently and experience a higher level of distress, emotional problems, clinical depression, and insomnia than grandparents in traditional roles (Song & Yan, 2012). Grandmothers in particular experience higher levels of stress, strain between family members, more severe physical symptoms, and severe depression symptoms (Musil, Gordon, Warner, Zauszniewski, Standing, & Wykle, 2011). This is especially true in cases where the grandmother has no high school diploma, is not employed, lives in poverty, and whose grandchildren possess severe behavioral problems (Park, 2009). These grandparents can also experience grief and disappointment over the primary parent's situation, adding to the intense emotional distress (Strom & Strom, 2011). In cases where the primary parent has been incarcerated, used or uses drugs, or suffers from AIDS/HIV, the stress of dealing with the children and the parent's problem can create a tense environment for the custodial grandparent. Additionally, if the child's parent has died, grandparents must simultaneously cope with their own grief as well as that of their grandchild.

In addition to impaired physical and emotional functions, intergenerational households headed by grandparents may experience social isolation due to the stigma attached to substance abuse, AIDS/HIV or incarceration of the absent parents (Harris & Kim, 2011). Custodial grandparents can also become isolated from their peers due to caregiving responsibilities. Such responsibilities may put them out of step with their peer group (Backhouse & Graham, 2012). The social isolation that grandparents experience may make management of their physical and emotional issues more difficult.

Purpose of the Study

According to Hayslip and Goodman (2007): “we have not spent as much time and effort in developing interventions which have proven beneficial to needy grandparents and grandchildren” (p. 118). Most literature related to this population either focuses on the grandchildren’s experiences (Downie, Hay, Horner, Wichmann, & Hislop, 2010), or the adjustment of grandparent caregivers as regards coping with stress, role theory, or functional/economic issues (Backhouse & Graham, 2012; Conway, Jones, & Speakes-Lewis, 2011; Musil, Gordon, Warner, Zauszniewski, Standing, & Wykle, 2011). The purpose of this qualitative study is to understand the experiences grandparents face and the challenges they experience while raising their grandchildren, particularly as it pertains to role changes and the effects on familial relationships as well as its attention to parenting practices in an attempt to provide suggestions for interventions.

Method

This research was conducted using phenomenology as the objective was to reveal the nature of human experience from the perspective of one who has lived it. Applied phenomenology utilizes open-ended, face-to-face interviews as a means of data collection (Patton, 2000). One way to understand the phenomena of grandparents becoming primary caregivers is to gather information from one-on-one interviews with these grandparents. As the participants reflect on their experiences, we begin to appreciate the challenges they face and the ways in which their lives changed.

Procedure

Participants. Participants were recruited through snowball sampling. The first author knew someone who was raising her grandchildren. From there, referrals were made for the researcher to contact other potential participants. The first author contacted potential participants via phone. Limitations for participants were as follows: they must have at least one biological grandchild living in the home for a period of at least six months without the presence of a biological parent. The biological parent(s) may be in contact with the family. The children's ages varied widely but were all under the age of 18. If the referrals agreed to participate in the research, semi-structured interviews lasting between 45-60 minutes were conducted. All interviews were recorded and transcribed. Participants were compensated in the amount of \$15 each. This study was approved by the University's Institutional Review Board.

Measures. Prior to the interview, a brief demographic form was completed by participants. This form included questions regarding age, ethnicity, gender, number of children and ages, and the length of time children were in the care of the participants.

Focused interviews comprised of a series of open-ended questions. Areas of interest included; the circumstances that brought the grandchildren into participants' care, the role changes that took place as a result of the placement, and how the relationship between family members changed. Grandparents were also asked to describe changes to their social life. Finally, they were asked to share any additional information about the experience of raising grandchildren.

Data Analysis. The data analysis portion was guided by Strauss and Corbin's (1990) procedures. This

approach outlines a means of extrapolating themes within data in order to explain a phenomenon. Because we were interested in determining meaning in the participant's experiences, we believe this to be the most appropriate method. We began by independently reading the interviews without analysis. Once completed, we again read the data and employed a bracketing method (Patton, 2002) to identify themes, paying particular attention to the participants' experiences related to their roles, as well as anything additional they reported. We then utilized analytic induction and constant comparison (Glaser & Strauss, 1967) as a means of organizing the data. We generated a refinement of themes by re-reading the interviews and reviewed, collapsed categories, and modified themes. After performing these tasks independently, we collectively compared our themes and categories. Through discussion, we worked toward an agreement of categories and themes.

Ensuring Rigor. Within two months of the initial interview, researchers followed up with participants with an email or phone call. To ensure creditability and remove bias, the second author worked with the first author to ensure that the themes and patterns detected were accurate. Three volunteers transcribed the interviews and an assistant reviewed the data for emerging themes. A reflexive journal was also kept to assess and manage potential researcher biases.

Findings

Ten grandparents (four grandfathers and six grandmothers) participated in the study. Ages of the participants ranged from 48 to 86, with an average of 58.4 years. Eight of the participants were married and two were single grandmothers. The range of time children were in the care of their grandparents was 9 months to 11.5 years, with an average of 8.5 years. The age of the children in care

ranged from 9 months to 18 years, with an average age of 10.5 years.

Five main themes emerged from the interviews: characteristics of everyday life, parenting experiences, lack of resources, managing negative emotions, and social changes. Each area is described in greater detail below.

Characteristics of Everyday Life

Involvement with multiple systems. This theme describes how families were involved in larger systems such as court systems, foster care, police, etc. All grandparents in this study were raising their daughter's children. With the exception of one family, all of the parents in these families were involved with drugs and most of the daughters are or had been incarcerated. One grandmother recalled:

"She was in high school and started this kind of behavior, you know boys and drugs and sneaking out and getting drunk and lying and you know, just this whole horrible spiral and we thought once she had her first child, that she'd, you know, kind of step up to the plate and those crazy behaviors would be done because hey, you know, I can't behave like that anymore and that, you know, that didn't happen and still hasn't happened. I love my daughter but I'm disappointed and... angry. My heart is broken. That she could do this...I just can't...I look at his little face and I just can't imagine that she could do this."

The feeling of disappointment with their daughters' choices left most of the participants feeling they had failed while raising their daughters. This influenced their decision to take in the children. Many of them did so in order to spare their grandchildren a life of mistreatment and neglect.

Trauma/abuse. Most children living in the home of a grandparent have suffered from some form of trauma or abuse. Some participants reported finding neglected children, without food or clothing, when they took them in. Others described lengthy court battles in order to provide a stable environment for the children. One family described the grandmother's struggles to keep her granddaughter on the right path. The child was born to a drug-addicted mother and suffers the consequences of her mother's choices. The grandfather admitted it takes extra patience not only to have the child in the home but also to remember she has a disability. He stated:

"Our granddaughter is an ADA child and you have to remind her every day that "no, you have to put that in garbage can and you can't leave it on the floor" and it's every day. It's repetitive every day. And it takes a tremendous amount. So you got to be patient. You got to say "wait a minute" before you get upset or raise your voice or start jumping up and down. You got to say "wait a minute this is a child that has problems."

Parenting Experiences

Leniency. Participants reported that they are more lenient with their grandchildren than they were with their own children. One grandparent stated:

"my standards are the same as when I was raising my own children. I have just become a little more lenient, a little less obsessed."

Most grandparents interviewed also reported having considerably more patience now than when they were younger. One participant stated:

"a spill is a spill now; instead of hollering and yelling that you spilled something, you get a towel and wipe it up."

Participants also reported they tend to buy more for the grandchildren living with them. Although money is often tight, it is spent on necessities such as clothing and glasses, as well as extracurricular activities and entertainment. Participants believed that keeping children involved in activities such as ice-skating, Scouts, gymnastics, and music lessons would prevent future problems. One participant stated:

“I’m more involved in her life. I was not the type of mom that did softball or the Girl Scout thing. I wasn’t into that stuff. I was more into partying really. I had one that turned out good and one that turned out bad. I failed my daughter so I’m hoping I don’t fail my granddaughter. I can only do my best and hope it is enough. I want her to grow up to be a good citizen and give back to society.”

Addressing today’s challenges. Some participants reported that maintaining the grandchildren’s involvement in activities prevented them from struggles children face today. One great-grandmother raising her 8-year-old great-granddaughter commented on the loss of security in today’s world. “Children are so susceptible to bad people and they have to be taught there are those people. I was not like that 50 years ago when I was raising my children.” Statements like this were common throughout the interviews. Participants reported feeling stressed trying to balance their grandchildren’s daily activities with safety issues of today.

Lack of Resources

Lack of financial resources. Participants in the study also reported experiencing an unanticipated financial burden. Most stated that they are spending their retirement savings on necessities for their grandchildren. Many spoke

of the stress that results from a lack of support from the biological parents. As one participant noted:

“The main thing is expense and we don’t seem to be getting any help from the parents. Her father, we haven’t seen him since last year and he swore when we last seen him that he would help and he hasn’t come through. I don’t see it happening. Her clothing, that’s the main expense. Her health, doctor appointments, dentist and clothing. Her mother comes around when she feels like it but again we get no help with money”.

This lack of parental involvement leaves grandparents with the problem of finding other ways to support their grandchildren. Most participants reported having difficulty finding financial aid, either in government or social services. Many participants stated that they are saving the government money by taking in the children instead of having the government place the children in foster care. One participant stated:

“...we are past our maximum earning period. There’s no help out there. Sure you can say, “Oh well, you’re the one that raised the bad kid that didn’t stick around to raise their kid.” I am willing to accept responsibility that my daughter didn’t turn out to be a responsible adult. I went to welfare and was treated like a piece of dirt. It was horrible. There will be no retirement money left. There should be some sort of program to help us. “

Lacking emotional/supportive resources.

Participants also reported lacking the energy needed to keep up with children. Children are time-consuming, and participants reported having little to no time to devote to themselves. One female participant summed it up by stating:

“Time management...trying to work full time on the other side of town and yet still get him to his activities on this side of town when I’m not here, knowing how much responsibility I can give him in making those arrangements. How much do I take? So that’s a balance. The other thing with time is I need to do some things for myself, spend some time with myself or with friends and not spend it completely with him. But yet, we’re just still trying to figure out that balance. “

When there is a lack of support, meeting the daily needs of both the grandparent and the grandchild becomes a burden.

Managing Negative Emotions

Resentment. Many of the grandparents interviewed in this study reported feeling resentful that they had lost the freedom they had enjoyed as retirees. They did not resent the children but rather resented being put in a situation to care for children again at this late stage of their lives. One participant asserted:

“It’s not a place you expect to be at 55. At 55, you expect to be with your grandchildren that they come and play and that you’re excited to see them and they’re excited to see you and just all little bundles of cuteness, you know, and that they have a happy little home to go to and you’re sharing things with your children and it’s just not that at all. I mean, not that he’s not a cute little bundle of cuteness, but there’s sadness and then there’s a responsibility. That’s what I feel. Raising grandchildren becomes a full time job with no vacation time.”

Strained relationships with other family members. The participants in this study reported changes in their relationships with other family members. For

example, the grandchildren often became jealous of other grandchildren not living in the home. They do not experience the novelty of visiting their grandparents and are, instead, subjected to discipline from their grandparents that other grandchildren who do not live with them do not experience. One participant described the struggle her family faces with the grandchildren who do not live in her home:

“I just don’t have the freedom to be as available to any of them... And it’s not that they don’t have fun with me, it’s just, it is different and I feel badly, but on the other hand all of my other grandkids are blessed with other grandparents. It’s not like...they don’t know me because they do, but they do have other grandparents.”

Further, other family members often raise concerns over the relationship. Many adult siblings of the missing parent feel a twinge of jealousy. They believed their children are not treated equally and that the grandchild living in the grandparent’s home is being favored. One grandmother stated that her daughter often became upset over the “special” treatment she felt her nieces received. The daughter often told the grandmother “you buy those kids clothes and shoes, take them to adventure parks, support their daily needs, and you tell me you can’t buy my children birthday or Christmas gifts. How is that supposed to make my kids feel? It’s not fair, I’m your child and my children are your grandchildren, too.”

Sacrifice of personal expectations. The guilt of not treating the grandchildren equally often creates feelings of being “shortchanged.” Grandparents are saddened by the perceived loss of the benefits of being a grandparent, rather than the responsibilities of a primary caregiver. They are forced to face the reality that they are, in essence, forced to

act as a parent again. Often while attending activities with their grandchildren, they are left feeling out of touch and exhausted. One grandfather stated “I look around and I am the oldest guy there. I wonder what the hell am I doing here? Then I remind myself it is okay, I have done this before.” Grandparents who raise their grandchildren do not resemble stereotypical images of grandparents. Most participants reported feeling as though their grandchildren keep them young and in touch with contemporary society. Many read articles in teen magazines to keep up to date while others join in activities such as soccer or softball, which has the added benefit of contributing to their overall health.

Social Changes

Immersion in children’s lives. All participants in this study agreed that they are immersed in the lives of their grandchildren but they disagreed about what that means. One participant stated:

“I’m just thankful that I am able to do it, you know. I know that there are a lot of grandparents that do this and that are in different circumstances for different reasons. I just look at it as an opportunity to make a difference in a kid’s life, and if I could do it for more children, I would like to.”

Others feel a sense of duty perhaps as a result of the perceived failure of raising their own children. This often causes friction between spouses. As reported in one interview:

“Well, immediately my husband and I didn’t agree on this at the start you know. Immediately I was just like “Ok, we’re taking the baby. We’ve got to raise him. We’re his family, we’re this, and we’re that.” And my husband’s opinion, you know, was that she needed to come get him. It’s her responsibility. It’s

her child. If she can't raise him then you know then what about the father? And the other grandparents and whatever. I just couldn't imagine...she's not going to raise him and I don't even know about these other grandparents. I know I can at least take care of him and keep him safe."

Separation from peers. Participants in this study found that raising their grandchildren impacted their social lives in unexpected ways. Many reported being unwelcome at events because they are raising young children. Some found it difficult to trust a babysitter and felt obligated to stay with their grandchildren. Participants reported changing travel plans to accommodate children. One participant stated:

"Well, we used to travel a great deal...We were free to go places but now we're limited because obviously our grandchild is in school. So now it is narrowed down to where you can go and of course you have to take her needs in consideration. For example, if you went to Alaska and went fishing on a fishing vessel, she's not going to enjoy that one bit. So now what we do is plan trips that are something that she would enjoy. It's like going back in time in a way. We go to places like Sea World or Disney World."

The participants reported putting aside their own desires in order to meet the needs of their grandchildren, which often left them with little peer interaction. Many participants reported being too tired or stressed to find time to socialize; yet none of the participants considered this particularly painful, and most had no ill feelings regarding the loss of a social life. They felt that raising the children was more important than dinner with friends or an exotic vacation.

According to one participant, “They’re family: you do what you have to do.”

Discussion and Clinical Implications

Daily life changes dramatically for grandparents raising grandchildren. Since every child in this study came from an abusive or traumatic situation, it became necessary for the grandparents to raise their grandchildren. The findings of this study are consistent with other research that determined that grandparents took custody of the grandchildren under disruptive circumstances, often when the parents were experiencing difficult problems, and it was typically an unanticipated, involuntary, and indefinite situation (Strom & Strom, 2011). The themes in this study are also consistent with those described by Lander (2011) with regard to the process of recovery for both parties as relates to the necessity of the new living arrangement. Many children may experience grief over their parents’ absence (Langosch, 2012). They may have residual problems such as disabilities, a physical addiction to a drug, or emotional or psychiatric disorders. Physical abuse by or incarceration of their parents may cause additional problems for children which can perpetuate the problem, as grandparents now must manage the anger and mistrust of their grandchildren.

Clinically speaking, therapists need to consider and address the underlying traumatic context that created the current situation. In addition to the trauma experienced by the children, therapists must fully understand the challenges faced by grandparents when offering support. Given that the grandparents in our study reported a greater focus on the needs of their grandchildren, it is possible they may neglect their own needs, resulting in depression and stress. Application of the Trauma-Focused CBT model (Cary & McMillen, 2012; Cohen, Mannarino, Kliethermes, & Murray, 2012) would likely be effective in working with

youth in GHF. In addition, Allen and Johnson (2012) note the portion of training most practitioners skip is the portion teaching child behavior management skills to the caretaker. Therefore, practitioners need to be sure that they are including all components of TF-CBT in order to provide the most relief to GHF.

While previous research has demonstrated that custodial grandparents present high rates of depression, poor self-rated health, and/or frequent chronic health problems, the grandparents in this study reported that their grandchildren keep them active and healthy. This is consistent with the research of Bailey, Letiecq, and Porterfield (2009) which found that a youthful presence in the home may play some role in moderating the impact on a grandparent's health. Other positive benefits to the children included increased to a child's self-esteem and sense of security. This knowledge can be useful to a therapist who can highlight the potential benefits of raising young children on self-care of the grandparents as well as the benefits on the children, thus increasing the utility of strength-based approaches in practice (Hayslip & Smith, 2013).

Participants in our study acknowledged feeling a lack of support, both emotionally and financially, adding credence to Kelch-Oliver's (2011) suggestion that there be avenues for seeking support for GHF. Resources could be dedicated to providing support for these families both in family therapy, support groups for grandparents, and concurrent support groups for the children. Because of the financial struggle for grandparents, such groups could be offered within family therapy or counseling training programs where the services would be little-to-no cost. Another alternative would be to have policymakers propose to provide some of these services as a normative part of the placement process. Such groups would address the feeling

of being alone and “out of touch” with others their age and would normalize the experience for GHF.

The most prominent theme in this study was the expressed desire to make the best of an unexpected situation. None of the participants reported regret at the decision to raise their grandchildren although many indicated a sense of disappointment in their own children for making poor choices that led to the current situation. Innovative practice methods in this area might include art-based therapies as a way to make different meaning of one's experiences (i.e., making different meaning of one's own child-rearing or the children's experience of trauma) as well as offering one a sense of control over an uncontrollable situation (Smilan, 2009). For example, rewriting personal narratives, specific scrapbooking techniques, and helping each member of the GHF live their reality as opposed to their expectation (Smilan, 2009) may be useful in creating a different meaning for those in GHF. In addition, therapists may work with GHF to effect accommodation coping (i.e., finding positive meaning) as a way to build resiliency (Vulpe & Dafinoiu, 2012).

Limitations and Future Research

A key limitation to our study was the small number of participants. We believe, however, that this is moderated by the depth of the information gleaned in the interviews as well as the saturation of the data and the fact that our findings were consistent with previous research. Future research may focus on replication with a different sample size. Additionally, we did not inquire as to the differences between younger and older grandparent caregivers and the effects that each may have on the development of their grandchild. Future research may explore how the age of both the grandparent and the grandchild affects their relationship. We also know little about the effects of the age of the children when they initially transition to living

with their grandparent. These differences may have implications for both the caregiver and the children. In addition, the efficacy of the suggested treatments (TF-CBT, resiliency training, etc.) on GHF and should be investigated in future research.

Correspondence: Katherine M. Hertlein, Ph.D., Program Director, Marriage and Family Therapy Program
University of Nevada - Las Vegas, 4505 Maryland Pkwy,
Box 453045, Las Vegas, NV 89154; email address:
katherine.hertlein@unlv.edu.

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*Research Article***Practice Recommendations for Mental Health Professionals: Perspectives from Grandparents and their Adolescent Grandchildren**

Kendra A. O'Hora
Megan L. Dolbin-MacNab
Virginia Tech

Abstract

Although grandfamilies are consumers of a variety of mental health services, less is known about what these families, particularly the grandchildren, want from practitioners. To gain insight into how practitioners can best meet the needs of grandfamilies, 40 custodial grandmothers and their adolescent grandchildren were interviewed. Results of a qualitative analysis indicated that grandmothers and grandchildren did not make clear distinctions between various types of services and service providers. Grandchildren emphasized the need for mental health professionals to facilitate mentoring and to provide opportunities for grandchildren to socialize with other grandchildren who have been through similar circumstances. Grandmothers and grandchildren both recommended promoting problem solving, offering services for grandchildren, and being responsive to their families' unique needs. Participants also suggested that practitioners avoid making judgments, educate themselves about grandfamilies, advocate for their families, and attend to the experiences of both grandmothers *and* grandchildren. Implications of the findings for mental health practitioners are discussed.

Keywords: grandfamilies, grandparents raising grandchildren, mental health

Grandfamilies include those families in which primary responsibility for the care of children falls to a grandparent (Littlewood, 2014). In the last 40 years, the percentage of children living in grandparent-headed households has steadily increased from three percent in 1970 to six percent in 2012 (U.S. Census Bureau, 2012). In the United States, approximately 7.8 million children live with a grandparent and approximately 2.7 million grandparents are raising 40% of these children (AARP, 2010; U. S. Census Bureau, 2012). As has been well-documented in the literature, grandfamilies often form because the grandchildren's parents are unable to care for them due to issues such as substance abuse, abuse and neglect, incarceration, HIV/AIDS, mental illness, divorce, emotional immaturity, military deployment, and death (Connealy & DeRoos, 2000; Jendrek, 1994; Kelley, Whitley, & Campos, 2013; Pinson-Millburn, Fabian, Schlossberg, & Pyle, 1996).

Previous research has established that grandfamilies experience wide-ranging needs that, if left unaddressed, can result in negative individual and familial outcomes. For instance, grandchildren raised by grandparents may experience depression, anxiety, posttraumatic stress disorder, health problems, behavior problems, academic difficulties, aggression, and feelings of anger, rejection, and guilt (Billing, Ehrle, & Kortenkamp 2002; O'Reilly & Morrison, 1993; Shore & Hayslip, 1994; Smith & Palmieri, 2007; Solomon & Marx, 1995). For their part, grandparents must cope with legal and financial problems, insufficient knowledge about contemporary parenting practices, difficulties with their adult children, health concerns, social isolation, and psychological distress (Hughes, Waite, LaPierre, & Luo, 2007; Jendrek, 1994; Minkler & Fuller-Thomson, 1999; Pinson-Millburn et al., 1996; Sakai, Lin, & Flores, 2011).

To minimize negative outcomes and enhance both individual and family well-being, there has been a proliferation of services and programs targeting grandparents raising grandchildren. Many of these services address mental health issues, namely issues related to grandparents' and (to a much lesser extent) grandchildren's emotional, psychological, and social well-being (MentalHealth.gov, 2014). Common services related to mental health issues within grandfamilies include support groups (Cox, 1999; McCallion, Janicki, & Kolomer, 2004; Minkler, Driver, Roe & Bedeian, 1993), resourcefulness training (Zauszniewski, Musil, Burant, & Au, 2013), and psychoeducational programs and workshops (Burnette, 1998). Support groups are "a way to provide emotional, educational, and psychological support and interventions [to participants]" (Littlewood, 2014, p. 33), while psychoeducational programs and workshops focus on providing resources and information about specific topics (Furman, Rowan & Bender, 2009). Although these services address mental health issues (MentalHealth.gov, 2014), it should be noted that the practitioners who facilitate support groups and psychoeducational programs might not uniformly identify these services as being within the purview of mental health treatment.

Support groups and psychoeducational programming are popular means of intervention with and support for grandfamilies. However, grandparents may seek out or require more intensive mental health services, such as family therapy or individual psychotherapy, for themselves and their grandchildren. For instance, family therapy, which involves treating mental health issues and family problems within the family context (AAMFT, 2014), can add value to services for grandfamilies by assessing the contextual systems in which grandfamilies exist and privileging the voices of all members of the family. Similarly, individual psychotherapy treats mental

disorders by helping clients understand their illnesses, manage their symptoms, and improve their daily functioning (National Institutes of Mental Health, 2014). These modes of mental health intervention are important to keep in the service landscape, as grandparents frequently report a desire for more intensive intervention and professional services targeting family-level and grandchild needs (Burnette, 1999; Landry-Meyer, 1999; Yancura, 2013).

Along with the growth of interventions for grandfamilies, there has been parallel growth in recommendations for their implementation. Existing intervention guidelines tend to be derived from service providers rather than the actual service recipients. However, scholars and practitioners have suggested that there is much that can be learned from the families who receive the interventions and services designed to assist them (e.g., Cox, 1999; Pinson-Millburn et al., 1996). While some existing research has examined the perspectives of grandparents (Smith, 2003), there has been little consideration of grandchildren's experiences of mental health services or services in general—even though there is consensus among service providers and grandparents that grandchildren are likely to benefit from them (Billing et al., 2002; Shore & Hayslip, 1994; Smith & Palmieri, 2007; Yancura, 2013). To address this issue and further the understanding of how to intervene most effectively with grandfamilies, the purpose of this study was to examine custodial grandmothers' and their adolescent grandchildren's practice recommendations for mental health professionals, though the results may have applicability to the wide variety of practitioners who provide service to grandfamilies.

Literature Review

With the growth in the numbers of grandfamilies and interventions designed to serve them, researchers and practitioners have given more attention to best practices related to services for grandparents and, to a lesser extent, their grandchildren. These practice recommendations tend to center on a variety of services that address mental health-related (MentalHealth.gov, 2014) issues pertinent to grandfamilies. Some of these services include support groups, psychoeducational programs, individual psychotherapy, and family therapy.

Support Groups and Psychoeducational Programs

Much of the literature examining interventions with grandfamilies has focused on support groups. Support groups have been widely recommended and implemented (Burton, 1992; Cox, 1999; Kolomer, McCallion, & Overendyler, 2003; McCallion et al., 2004; Minkler & Roe, 1993; Strom & Strom, 2000; Strozier, 2012) and are the most common type of mental health services used by grandparent caregivers (Littlewood, 2014; Minkler et al., 1993; Smith, 2003). When implemented effectively, support groups provide grandparents with opportunities for social support, communal problem solving, and psychoeducation. Common topics addressed in support groups include parenting, legal rights, social issues, financial support, grief and loss, grandchild behavior problems, and stress management (Wohl, Lahner, & Jooste, 2003).

Despite the potential advantages of support groups, they are not without challenges. Smith (2003), following an examination of 42 custodial grandparents' perspectives on support groups, concluded that many support groups are ineffective and potentially harmful because they foster self-pity and complaining, lack structure and skillful leadership, overemphasize self-help, and lack well-articulated goals

and objectives. Other challenges include encouraging attendance, promoting retention, and ensuring cultural sensitivity. To respond to these challenges, researchers suggest that support groups leaders provide participants with meals, attendance incentives, transportation, and childcare (Burnette, 1999; Dannison & Smith, 2003). Additionally, grandparents should be involved in the conceptualization and implementation of the group, trust the group leaders, and view leaders as credible (Dannison & Smith, 2003; Grant, Gordon, & Cohen, 1997). While there is value in providing time for personal sharing (Dannison & Smith, 2003; Hayslip & Kaminski, 2005; Strom & Strom, 1993), support groups should also address advocacy, education, and skill building (Burnette, 1999; Cox, 1999; Hayslip & Kaminski, 2005; Strom & Strom, 2000; Wohl et al., 2003). Strom and Strom (2000), in particular, encourage group leaders to avoid a negative focus by encouraging optimistic attitudes, providing guidelines for discussion, facilitating social support from outside the group, promoting increased knowledge, and encouraging goal setting and the evaluation of goal attainment.

As support groups and psychoeducational programming with grandparents raising grandchildren have proliferated, researchers have also given more attention to their effectiveness. For example, using a research design that employed random assignment, Hayslip (2003) found that grandparents who participated in a support group targeting parenting skills and psychosocial adjustment displayed decreased negative affect, increased parental self-efficacy, and an improved grandparent-grandchild relationship. However, participants also reported increased role strain, financial strain, and depression. In another study, Kelley, Whitley, and Campos (2014) recruited 504 African American grandmothers raising grandchildren and found that grandparents participating in support groups,

parenting classes, and case management showed benefits in their overall health and satisfaction with life. Similarly, Kolomer, McCallion, and Janicki (2002) found that grandparents participating in a support group reported decreased depression and increased locus of control, while Collins (2011) found that a faith-based support group for African American grandmothers was effective in addressing their financial, legal, health, and socio-emotional concerns. For their study of a two-year community support program, Smith and Dannison (2003) found that grandparents reported decreased depression and isolation, improved parenting knowledge, greater social support, greater willingness to access resources, and greater enjoyment of time with their grandchildren. Finally, Zauszniewski and colleagues (2013) found that resourcefulness training was more effective in minimizing stress and promoting mental health than “expressive writing, verbal disclosure, and attention control conditions” (p. 42). Thus, while there is growing evidence that support groups and other types of psychoeducational programming may be helpful for grandparent caregivers, the rigor of these research studies has improved greatly. However, more information is needed about the long-term impacts of these interventions, especially how well they work in comparison to other types of interventions and what grandparents are most likely to benefit from them (Hayslip & Kaminski, 2005).

In considering the effectiveness of interventions for grandparents, it is important to note that most discussions of programming for grandfamilies have focused on grandparent groups. However, grandparents also report needing help with their grandchildren’s difficult emotions and behaviors (Burnette, 1999; Landry-Meyer, 1999). When support groups provide activities for grandchildren, they often take the form of childcare and do not formally address grandchildren’s psychological and emotional

needs. One exception is the pilot work of Smith and Dannison (2003), in which they found that 3- to 6-year-old grandchildren participating in a therapeutic playgroup had improved self-esteem and peer interactions. Also improved were grandchildren's perceptions of the quality of their relationships with their grandparents. Dannison and Smith (2003) recommend that grandparent support groups provide therapeutic programming for grandchildren. They also recommend that this programming include small adult to child ratios, opportunities for play, consistent routines, and frequent feedback to grandparents. Additional recommendations include emphasizing the development of self-esteem and social skills as well as increased awareness of emotions and diversity in families. Despite these recommendations, in comparison to the work on grandparent interventions, relatively little is known about how to best intervene with the grandchildren in grandfamilies, or how to intervene systemically to address relational issues between the grandparent and grandchild.

Individual Psychotherapy and Family Therapy

Despite the potential value of support groups and psychoeducational programming, grandparent caregivers often need or seek more intensive mental health services for themselves and/or their grandchildren. These services may include individual psychotherapy or family therapy. For instance, in a case study of a boy orphaned and cared for by his grandparents, Lander (2011) advocates for family therapy with grandfamilies and explains how family therapy can help ameliorate grandchildren's posttraumatic stress symptoms, while transforming communication patterns surrounding distress, trauma, and pain. Additionally, in her study of 74 Latino grandparents, Burnette (1999) found that 52.7% of grandparents had obtained counseling for a grandchild, 45.9% had received individual counseling, and 9.5% had sought marital or

family therapy. Similarly, Landry-Meyer (1999) found that counseling for the grandchild was a significant need for 72.9% of a sample of 186 grandparent caregivers. Sixty-one percent of grandparents also indicated a need for individual counseling. As these studies demonstrate, grandparents see the value of therapy, particularly for their grandchildren, and some actively seek these services.

Though grandparents and grandchildren may experience individual mental health problems that may benefit from therapy (e.g., depression and anxiety), many of these issues have relational components and grandfamilies may experience family or relational challenges as well. Common family challenges within grandfamilies include family conflict, difficulties with the middle generation, marital distress, trauma, parenting, and finances (Strong, Bean, & Feinauer, 2010). With its emphasis on relational dynamics and patterns of interaction, family therapy is a treatment modality especially suited to the needs of grandfamilies. Although there have been no published examinations of family therapy's effectiveness with grandparent caregivers and their grandchildren, several theoretical perspectives have been highlighted as being uniquely applicable to this population. These theoretical perspectives emphasize the importance of examining and supporting proper family boundaries and hierarchies (Bartram, 1994), addressing issues of loyalty and feelings of debt/entitlement (Brown-Standridge, & Floyd, 2000), targeting resilience in grandparents to nurture resilience in grandchildren (Zuckerman & Maiden, 2013) and supporting a positive family narrative (Bachay & Buzzzi, 2012). In terms of working with grandchildren, several theories highlight the value of play techniques (Bratton, Ray, & Moffit, 1998) and attachment concepts (Strong et al., 2010). The assumption is that strong attachment bonds and a secure space for play between the grandparent and grandchild will

promote healing for the grandchild and the family system (Bratton et al., 1998; Strong et al., 2010).

Regardless of the specific theoretical basis or constellation of therapy (i.e., individual vs. family), many practitioners recommend a multimodal approach that includes individual therapy for the grandparent and grandchild, as well as conjoint family sessions (Strong et al., 2010). Yet, a multimodal approach would also suggest that grandfamilies can benefit from being connected to community services such as health care or emergency assistance (O'Reilly & Morrison, 1993), as well as to other programs offering nutrition assistance, legal assistance, or financial management training (Yancura, 2013; Letiecq, Bailey, & Porterfield, 2008). Whatever the exact combination of services being utilized or provided, cultural competence and humility among professionals working with grandfamilies has also been deemed as being very important to grandfamilies' successful outcomes (Bachay & Buzzi, 2012)—clinicians being a crucial tool in bridging gaps in order to provide grandparents and grandchildren with the help they need.

The Present Study

As numbers of grandfamilies continue to grow and more grandparents and grandchildren seek a variety of services, particularly mental health-related services (e.g., support groups, individual therapy, family therapy, and psychoeducational programming), it becomes essential to examine their experiences related to accessing available interventions and resources. Existing practice recommendations, while fairly extensive, have focused on support groups rather than other approaches to intervention. Moreover, with a few exceptions (Burnette, 1999; Landry-Meyer, 1999; Smith, 2003), practice recommendations have not been obtained from the actual service recipients. Moreover, and perhaps most significantly, these

recommendations rarely take into account the perspectives of the grandchildren—despite evidence that grandparents report desiring services for their grandchildren (Landry-Meyer, 1999; Yancura, 2013).

The current study was developed to address these limitations and to gain insight into how to best intervene with custodial grandmothers and their adolescent grandchildren in the context of mental health services. The goal of this exploratory study was to answer the research question, “What recommendations do custodial grandmothers and their adolescent grandchildren have for therapists interested in improving mental health services with grandfamilies?” Through this exploration of grandmothers and grandchildren’s recommendations for intervention, aspects of mental health treatment and service provision central to the satisfaction of both grandparents and their grandchildren are identified.

Methods

This study uses data from a larger mixed-method study examining grandchild adjustment and family functioning within grandfamilies. Participation in the larger study involved grandparents and adolescent grandchildren completing self-report questionnaires. Grandparents and grandchildren were also invited to participate in semi-structured, qualitative interviews. Fifty-two grandparent/grandchild pairs completed questionnaires, with 41 dyads consenting to the interviews. This analysis examines only the interview data.

Participants

Participant families were recruited nationally. Thirty-nine dyads were recruited through support groups listed on AARP’s Grandparent Information Center. One pair was recruited through a website dedicated to grandparents raising grandchildren. The final pair was

recruited via word-of-mouth. Because of this approach to recruitment, the majority of participant families had some exposure to services and programs for grandfamilies. While specific information about the nature of the participants' current and previous service utilization was not obtained, some families anecdotally reported experience with support groups, psychoeducational programs, as well as individual and family therapy. Participants also informally reported accessing other services including financial assistance and low-cost medical care.

To be included in the study, grandparents had to meet the United States Census Bureau (2002) definition of a grandparent raising a grandchild. Specifically, grandparents were required to have at least one grandchild residing in their home and be primarily responsible for meeting that grandchild's needs. Additionally, due to IRB requirements, grandparents were required to have a legal relationship with their grandchild. Finally, as the larger study examined the adjustment of adolescent grandchildren, grandparents had to be raising at least one grandchild between the ages of 11 and 18. Of the 41 grandparents interviewed, 40 were female. Only data from the 40 grandmothers and their grandchildren were used in this analysis, as a means of providing clarity about who participated in the study and precision about the potential transferability of the findings (Gale & Dolbin-MacNab, 2014). Families were from 14 states in the Northeast, Midwest, South, and Southwest. Table 1 reflects the demographic information of the participant families.

Table 1

Demographic Information for Participant Families (N = 40)

	Grandchildren (GC)				Grandparents (GP)		
	<i>n (%)</i>	<i>M (SD)</i>	Range		<i>n (%)</i>	<i>M (SD)</i>	Range
Age (Years):		14.1 (1.74)	11 – 18			61.08 (7.59)	48 - 76
Race:							
African-American	10 (25)				9 (23)		
White, Non-Hispanic	22 (55)				26 (65)		
Multiracial	8 (20)				4 (10)		
Native American					1 (3)		
Gender:							
Female	19 (48)				40 (100)		
Male	21 (53)						
Contact with Parents				Married (Yes):	14 (35)		
(Yes):	28 (70)						
Mother	18 (45)						
Father							
Caregiving Arrangement:				GP Education:			
GP Years Caregiving		10.31	1 – 17	Less than HS	2 (5)		
Number of GC		(4.52)	1 – 5	HS Degree	28 (70)		
		2.10 (1.13)		College Graduate	10 (25)		
Annual Household							
Income:	12 (29)			Relation to GC:			
< \$15K	13 (33)			Maternal GP	30 (75)		
\$15K - \$25K	9 (23)			Paternal GP	10 (25)		
\$25K - \$50K	4 (3)						
> \$50K							

Procedure

Interested grandmothers and grandchildren were screened over the telephone for eligibility. If they met the inclusion criteria, a data collection session was scheduled in a location of the grandmother's choosing ($n = 7$) or over the telephone ($n = 33$). Telephone data collection occurred when participants lived beyond a reasonable driving distance. For face-to-face data collection, participants completed the consent forms, filled out the questionnaires, and were then interviewed separately. For telephone data collection, verbal consent was obtained, families completed the questionnaires, and separate grandmother and grandchild interviews were conducted. All interviews were audio-taped and transcribed verbatim. During data analysis, any potential differences in the interviews, based on type of data collection, were examined. These analyses revealed no notable differences in terms of the length of interviews or the depth of responses based on face-to-face versus telephone data collection. Grandmother interviews were approximately 30 to 45 minutes in length, although one lasted two hours. Grandchild interviews tended to be shorter, primarily as means of preventing participant fatigue, and ranged in length from 15 to 30 minutes. As compensation, each grandmother-grandchild pair received a \$15 gift certificate to a local restaurant.

Interview Protocol

During the interviews, grandmothers provided their age, gender, racial and ethnic background, and educational attainment. Grandchildren also provided their age, gender, grade level, and racial and ethnic background. Additionally, grandmothers identified their household income, relationship status, the length of the caregiving arrangement, and whether their grandchild had contact with his/her parents. Open-ended interview questions elucidated participants' recommendations for improving mental health

services. Beyond asking about overarching recommendations, participants were also asked to describe any positive and negative experiences with mental health services and to provide specific recommendations for how mental health professionals could better support and treat grandfamilies.

In describing the interview questions, it should be noted that the questions originally focused on grandfamilies' recommendations for family therapists. In fact, in advance of asking the interview questions, the interviewer defined family therapists as mental health professionals who are trained to work with families to address their relationship challenges (AAMFT, 2014). Despite giving this definition, it became apparent from the initial data analysis (which began while the interviews were ongoing; Charmaz, 2006) that most dyads failed to distinguish family therapists from other practitioners who might provide mental health services. In reflection of this observation, as the interviews progressed, the protocol was refined (Charmaz, 2006) so that participants were encouraged to provide recommendations for family therapists as well as any professional whose job it was to provide mental health (i.e., emotional, psychological, or social health) services to grandfamilies. Participants were given examples of these types of practitioners, including counselors, therapists, and some types of group leaders.

Data Analysis

To identify patterns in grandmothers and grandchildren's recommendations for mental health professionals, the constant comparison method was employed (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This method, which is most often associated with the grounded theory approach, allows for an examination of themes within the data that can then be organized for the purposes of providing an explanation of the phenomena

under investigation (Glaser & Strauss, 1967; Strauss & Corbin, 1990). A goal of this method is to accurately give voice to participants and to highlight how they make meaning of their lives (Glaser & Strauss, 1967).

Data analysis began by reading each interview transcript in its entirety. The family was the unit of analysis. Using the strategy of open coding, each transcript was reread and margin notes were made regarding possible categories of information (Strauss & Corbin, 1990). Next, transcripts were reread again and axial coding was used to identify the conditions of and relationships between categories. Categories were then organized into themes (Strauss & Corbin, 1990). Following this step, themes were either confirmed or disconfirmed by returning to the transcripts. Finally, transcripts were reviewed to identify passages that represented the various themes and to calculate their frequency or variation.

Because qualitative research is evaluated through evidence of trustworthiness, multiple strategies were used to enhance trustworthiness of the data analysis process (Lincoln & Guba, 1985). First, to account for researcher bias, process notes were made during data collection and analysis. As mental health professionals, reviewing and discussing these notes helped us stay aware of our biases and realize, for instance, that participants might not make clear distinctions between family therapists and other mental health practitioners. To obtain a critical evaluation of the themes, as well as to consider alternative explanations of the data, results were discussed with colleagues familiar with grandparents raising grandchildren. These discussions resulted in the realization that grandfamilies may be more concerned with quality of services received versus the type of services or type of practitioner. Similarly, conversations with colleagues challenged us to more carefully identify the recommendation made by the grandchildren. Finally,

because few new themes arose after coding approximately 25 interviews, it was possible to conclude that saturation had been reached (Patton, 2001).

Findings

One of the most notable findings to come from the overall analysis was that grandmothers and their grandchildren did not differentiate between types of mental health providers, mental health services, or even other types of services and human service professionals. Although the interview questions were originally about recommendations for family therapists, the analysis revealed that grandmothers, in particular, seemed most concerned about getting needed assistance and having their needs met—regardless of who delivered those services and in what format. Thus, the findings presented here reflect our dyads' suggestions for a variety of professionals who address mental health issues, broadly defined, in grandfamilies.

Beyond this overall finding, our analysis identified five specific themes related to service recommendations for mental health professionals. These include tailoring service provision, offering services for grandchildren, monitoring biases, creating space, and engaging in advocacy. In the following sections, each theme is discussed and illustrated with participant quotations.

Tailoring Service Provision

Twenty-two (55%) grandmothers suggested that mental health professionals, when leading support groups or psychoeducational programs, could improve their services by being more responsive to the needs of custodial grandmothers and grandchildren. More specifically, grandmothers suggested that support groups offer meals, provide educational content, create socialization opportunities, and develop respite activities. For example, a 76-year-old grandmother suggested:

“Feed the kids. Give them pizza and juice, and stuff like that. Give the kids help with their homework or play games. The grandparents can be in another place, and they can meet with experts who come in to talk about things.”

Grandmothers also reported that interventions focusing only on empathy or venting did not fully meet their needs. When the focus was only on obtaining support or expressing difficulties, grandmothers believed that the tone became too problem-focused. Thus, while grandmothers appreciated the opportunity to discuss their challenges, they also wanted to move past venting to finding ways to solve problems. A grandmother raising three grandchildren described her frustration with the atmosphere of her local support group:

“I don’t go anymore because I really get tired of hearing people constantly whine. The whining and dwelling upon problems only makes you feel terrible. It’s sort of like, if the milk spills wipe it up and buy a new gallon instead of saying, ‘I spilled the milk all over the floor, blah, blah, blah.’ I find that there’s a lot of that.”

Grandmothers described mental health professionals as being the key to shifting the focus from venting to problem solving. That is, participants saw practitioners as being responsible for effectively managing group dynamics so that group could be as productive as possible. To illustrate, one grandmother suggested:

“It’s important that support groups be led by someone who has an understanding of grandparents and who is able to assert themselves and take charge, because in some of the groups that I have gone to, the facilitator didn’t have the skills to

intervene, when someone was monopolizing the time, or when someone got off on a tangent.”

Finally, in terms of tailoring services to the specific needs and experiences of grandparents raising grandchildren, one grandmother recommended that mental health professionals use counseling skills or individual interventions to work specifically on grandparents’ problem-solving and coping skills:

“Work one-on-one with the grandparent to identify problems they can do something about, and problems they can’t do anything about. Then taking the problems that they can’t do anything about, and asking what they can do to make themselves feel better.”

Offering Services for Grandchildren

Both grandmothers and grandchildren ($n = 21$, 53%) recommended that mental health professionals develop and offer services specific to the emotional and behavioral needs of grandchildren. Grandmothers described a need for individual or group therapy targeting grandchildren’s feelings about their parents, experiences of being different from their peers, and reactions to their family arrangement. For example, a 51-year-old grandmother raising her 13-year-old granddaughter stated, “It’s natural [for the grandchild] to have feelings about the situation. They need to talk about it. They need to get it out. And a professional person can help them understand their feelings.” Similarly, a 13-year-old granddaughter suggested:

“They [professionals] can do like a program, to like all the kids that are raised by their grandparents, and they can talk to each other. If one of the kids is having a problem, they can ask some of the other

kids who have went through it already, and get good advice from them.”

For their part, grandchildren recommended that practitioners provide children being raised by grandparents with mentoring, career counseling, tutoring, and outlets for safe socializing. For example, an 18-year-old grandson suggested that service providers could help him reach his future goals when he said, “Help me more with my school, or things about my future.” If the professionals themselves did not offer these services, grandchildren thought that they should develop these types of services or connect grandchildren with existing resources. For grandchildren, mental health professionals were viewed as the people most able to help them locate and access resources they felt unable to access themselves, but knew that they needed.

Monitoring Biases

Twenty-four (60%) grandmothers and grandchildren described situations where they felt judged by the mental health professionals working with them. They referenced feeling judged by a variety of professionals including family therapists, support group leaders, and social workers, among others. Grandmothers believed that, because they were parenting a second generation of children, professionals often assumed they had dysfunctional parenting skills or family dynamics. They also felt judged regarding their motivations for raising their grandchildren. A grandmother raising four grandchildren shared her experience:

“It’s like you’re constantly being judged. Whether it is verbally spoken aloud or not, you are. The other thing that I hear is ‘If you were a better parent, then this wouldn’t have happened.’ Or, ‘Why don’t you let your kid raise their own kid?’ And it’s totally out of ignorance. Most grandparents who are raising

grandchildren never wanted to be put in that spot. They actually wanted to be grandparents.”

Grandmothers were not alone in feeling judged by service providers. Grandchildren were also aware of these judgments and experienced them as well. For instance, a 16-year-old grandson described his experience of being judged by his family’s caseworker:

“It tends that kids who are adopted by their grandparents tend to be troublemakers. They [professionals] need to not be so judgmental of them. Because a lot time, some of the people who are adopted by their grandparents come from homes where they had been pretty much taught to lie, cheat, and steal.”

When grandchildren and grandmothers felt judged, they typically attributed it to a lack of awareness on the part of practitioner. That is, participants perceived mental health professionals as being generally unaware of grandchildren’s issues, the challenges associated with the grandchild’s parents, and the impact of contextual factors (e.g., grandparent health problems and age-related limitations, being a racial and/or ethnic minority, and inadequate financial resources) on personal well-being and family interactions. For example, a 67-year-old grandmother shared how she wished that mental health professionals were more aware of the impact of her age on her caregiving ability:

“They need to take into consideration that my energy level at my age is far less than it was 10 years ago. People expect me to be available to go there, to do this. I think they really must know that the grandparent raising a grandchild’s energy level is going to be lower. It’s doesn’t mean that they aren’t capable, but if the energy level is low enough

then they need to take this into consideration when expecting grandparents to attend or do for the grandchild.”

Grandchildren, for their part, tended to share their grandmothers' perspectives that mental health professionals needed to be more educated about grandfamilies and needed to carefully monitor their biases and negative stereotypes. For example, a 14-year-old granddaughter suggested that mental health professionals learn more about how grandchildren view their family situations: “They [professionals] don’t really get it sometimes. You know, they’re [grandparents] just like your parents.” Similarly, a 15-year-old grandson suggested that therapists recognize the diversity that exists within grandparent-headed families: “Most of them pretty much think all grandparents and grandchildren are basically the same, but they’re not. They think the kids are misbehaving. They might need to change that.” As these quotes illustrate, grandchildren were acutely aware that professionals were making negative assumptions about them and their families, and attributed to this to a lack of knowledge or general insensitivity.

Creating Space

Beyond monitoring their biases and becoming more educated about grandfamilies, grandmothers and grandchildren ($n = 11$, 28%) also recommended that mental health professionals be more intentional about listening to the concerns of *each* family member. They suggested that practitioners should listen to everyone’s perspective on their problem or situation, especially before offering solutions. Grandchildren, in particular, believed that professionals needed to be more active in ensuring that their voices are heard in therapy sessions or other practice settings. For example, a 16-year-old granddaughter suggested, “Listen to the kids more, and don’t take sides.

Just listen to both sides.” Grandchildren were also reactive when they perceived professionals as giving them advice, instead of focusing on listening to them and trying to understand their experiences. For example, a 13-year-old granddaughter suggested, “If you say something and you don’t want advice, don’t me give advice, just listen. Then they [counselors] always give you advice anyway. I know they’re counselors, but I think sometimes they should listen to you and then if you don’t want advice don’t give it to you. Just talk.” Grandmothers also echoed the importance of practitioners avoiding giving advice or assuming that they know what grandfamilies are experiencing. For instance, a 69-year-old grandmother raising two grandchildren stated, “Unless you [practitioners] walk in our shoes, you really don’t know what’s going on. They can go by what they pick up and read, but unless they’ve truly walked in our shoes, they really don’t know what’s going on.”

Engaging in Advocacy

Finally, grandmothers ($n = 19$, 48%) wanted mental health professionals to work alongside them to engage in advocacy efforts. Grandmothers believed that influential members of their communities were largely unaware of the presence and needs of grandfamilies. Therefore, grandmothers suggested that professionals work alongside them to help community leaders realize the scope of the issue and respond to their needs. For example, a grandmother raising three grandchildren suggested that professionals “network with us. We need to let the community know the numbers [of grandparent caregivers] because sometimes grandparents feel embarrassed. We want professionals to join our strength in numbers.” In addition to perceiving more power in numbers, grandmothers also believed that service providers have the status and power necessary to meaningfully impact larger

systems such as schools, agencies, and governments for the purpose of creating positive social change. Specifically, grandmothers suggested that practitioners advocate for increased grandparent rights such as access to affordable medical care, financial assistance, and legal authority. For example, a grandmother raising a 14-year-old grandson said, “grandparents need more rights. They shouldn’t have to fight for everything. [Professionals] should help get more legislation for grandparents. Financial help in some cases too.” Grandchildren tended to focus less on these types of suggestions for advocacy, as their concerns and recommendations primarily revolved around their individual needs and relationships.

Discussion

As numbers of grandfamilies continue to grow, their needs have come to the attention of mental health professionals and a variety of other service providers. Existing practice guidelines offer professionals, particularly those leading support groups, important suggestions regarding effective group leadership and implementation (e.g., Dannison & Smith, 2003; Kolomer et al., 2003; McCallion et al., 2004). Additionally, applications of family therapy models to grandfamilies highlight various theoretical approaches for addressing the relational needs of custodial grandparents and their grandchildren (Bachay & Buzzi, 2012; Bartram, 1994; Bratton et al., 1998; Brown-Standridge & Floyd, 2000; Strong et al., 2010). Individual psychotherapy, family therapy, psychoeducational programs, and other mental health services are seen as important interventions for grandfamilies (Burnette, 1999; Strozier, 2012). However, there has been limited information about custodial grandparents’ suggestions and recommendations for mental health practitioners. More significantly, prior to this study, there has been virtually no information about grandchildren’s perspectives on best

practices for mental health interventions with grandfamilies.

To begin addressing these needs, this study explored practice recommendations custodial grandmothers and their adolescent grandchildren had for mental health professionals. One of the most significant findings was that grandparents and grandchildren did not seem to distinguish between various types of mental health services (e.g., support groups, psychoeducational programs, individual therapy, or family therapy) or types of mental health professionals. While this is useful in terms of the applicability of the findings to a variety of practitioners and practice settings, it also suggests that grandfamilies may benefit from education about different types of mental health professionals, what they do, and the range of services available to them. They may also benefit from guidance on selecting services and providers that can best meet their needs. More specifically, as grandfamilies may believe that support groups are the only option available or appropriate for them (Szinovacz & Roberts, 1998), it is imperative that families become educated consumers about available resources, and about how multimodal approaches may benefit their family and individual well-being (O'Reilly & Morrison, 1993; Strong et al., 2010; Valentine, Jenkins, Brennan, & Cass, 2013).

In terms of specific findings, given the lack of empirical attention that has been given to grandchildren's experiences with interventions for grandfamilies, their recommendations for mental health professionals are particularly valuable. First, grandchildren reported feeling judged by the professionals tasked with helping them. Thus, grandchildren's recommendations that professionals monitor their personal biases about grandfamilies and try to understand the unique experiences of each family member highlights the necessity of a strong professional relationship between grandfamilies and mental health

providers. Without it, grandchildren may not feel comfortable opening up to or accepting help from practitioners. Similarly, grandparent caregivers may choose not to reach out for needed services because of a lack of trust or a fear of being judged (Gladstone, Brown, & Fitzgerald, 2009; Strom & Strom, 2000). Clearly, both the grandmothers and grandchildren in this study were attuned to feeling judged and wanted practitioners to avoid making negative assumptions about their family structure and interactions.

Although components of a strong professional relationship were central to participants' recommendations for mental health professionals and other service providers, grandmothers and grandchildren also wanted mental health professionals to offer services that were tailored to their instrumental and emotional needs. This was especially true for grandchildren, who wanted mental health practitioners to hear their voices and not take sides in a conversation. Further, they wanted practitioners to respect their ideas and stay away from advice giving—an important distinction, as grandchildren may merely want to be heard, whereas grandmothers may want direction, instruction, or suggestions.

Although the literature on grandfamilies frequently discusses the difficulties experienced by grandchildren and their need for mental health services (Billing et al., 2002; Lander, 2011; Smith & Palmieri, 2007; Yancura, 2013), intervention with grandchildren has been largely neglected. Dannison and Smith (2003) recommended population-specific services for young grandchildren. Additionally, Smith (2003) found that grandparents wanted their grandchildren to participate in grandchild or family groups. Yancura (2013) identified unmet services needs of grandparents raising grandchildren and determined that the vast majority of grandparents desired programs for their grandchildren and were not having this service need met.

Despite these studies, little existing work has examined grandchildren's own ideas about accessing and utilizing services. In this study, grandchildren and their grandmothers indicated that mental health professionals should develop more interventions for grandchildren. Their ideas for beneficial interventions included therapy and support groups, as well as other services such as mentoring, career counseling, academic support, and structured opportunities for safe socializing. Perhaps because of the awareness of their grandparents' limitations (e.g., energy and generational differences) and their nontraditional family structure, grandchildren seemed most interested in services that would help them feel more like their peers and plan for their futures. Grandchildren's diverse ideas for services offers additional support for O'Reilly and Morrison's (1993) argument for a multimodal approach to working with grandfamilies and remind all practitioners of the importance of looking beyond one type of intervention and connecting grandparents and grandchildren to multiple resources in the larger community. Utilizing a multimodal approach when working with grandfamilies would provide grandparents and grandchildren with a viable option for addressing a variety of relational, personal, and instrumental needs.

Grandmothers' recommendations regarding tailoring interventions to meet their specific needs largely reflect existing practice guidelines (Burnette, 1999; Dannison & Smith, 2003; Smith, 2003) regarding the structure and delivery of interventions, namely support groups. Although this particular theme may seem less relevant to practitioners who do not lead support groups, it does draw into focus the importance of working with grandparents to remove as many barriers (e.g., lack of childcare or transportation) to service utilization as possible. It also highlights the importance of professionals becoming sensitive to how grandfamilies' barriers to

service utilization might impact their ability to access needed supports.

In terms of how mental health professionals can tailor their services to meet the needs of grandfamilies, one interesting subtheme was that grandmothers wanted practitioners to move away from venting and toward solving problems and attaining goals. Many scholars have already argued that support groups can be counterproductive when there is too much emphasis on self-pity and complaining (Smith, 2003; Strom & Strom, 2000; Szinovacz & Roberts, 1998). Therefore, in addition to providing support, support groups should include opportunities for advocacy, goal setting and evaluation, education, and skill building (Burnette, 1999; Cox, 1999; Hayslip & Kaminski, 2005; Strom & Strom, 2000; Wohl et al., 2003). By confirming this information, from the perspective of grandparents themselves, it is apparent that focusing on solutions (de Shazer, 1988) is an important practice recommendation. Where this study extends previous work is revealing that grandmothers viewed practitioners as being primarily responsible for maintaining a focus on problem-solving and goal attainment, and that a lack of training in group dynamics can seriously undermine the effectiveness of an intervention.

Somewhat unexpectedly, the grandmothers in this study were also able to take a more macro perspective and recommended that mental health professionals take a stance and become active in advocating for grandparent rights. Perhaps paralleling the emphasis that grandmothers put on their relationship with service providers, it seemed important for the grandmothers in this study to know that the professionals working with them were on their side and willing to speak (and advocate) on their behalf. This finding also points to the recognition by grandmothers that mental health professionals and service providers possess the power necessary to help them obtain the resources and

services (e.g., health insurance, financial support, legal rights) necessary for parenting a second generation of children. Scholars have advocated for policies that support grandparent caregivers (Smith, Beltran, Butts, & Kingson, 2000). To hear this same recommendation from grandmothers themselves further highlights the broader nature of the issue and the need for all professionals to consider their roles in advocating for grandparents and grandchildren within their local communities, as well as nationally.

Limitations

Although the findings from this study provide useful suggestions for mental health professionals working with grandfamilies, its limitations are acknowledged. First, while the demographic characteristics of the current sample compare favorably to national samples, the families who volunteered for the study were primarily White and do not fully reflect the diversity that is present in grandfamilies. Thus, findings may not be applicable to all grandfamilies, particularly to groups with a history of negative experiences with mental health services. Also, as recruitment occurred primarily through support groups, it is possible that participants differed from other grandfamilies in terms of their exposure to and comfort in talking about mental health and community services. Another limitation of the study is that participants' history of mental health treatment or service utilization was not obtained, although some participants did offer this information spontaneously. Further, because participants did not make clear distinctions among various mental health services and professionals, the degree to which grandmothers and grandchildren were making fully informed recommendations is unknown. Finally, the formal legal status within these grandfamily relationships raises concerns about how grandfamilies with informal caregiving

arrangements might differentially experience mental health services. Despite these limitations, the findings of from the study still provide important insights into ways that mental health professionals can improve services for custodial grandmothers and their adolescent grandchildren.

Directions for Practice and Research

The themes identified in this study highlight important ways that mental health professionals can tailor their work with grandfamilies. The finding that participants wanted services that are more responsive to their particular needs suggests that, when applicable and appropriate, programming for grandfamilies could include childcare, meals, and transportation. Opportunities for education, support, and socialization for both grandparents *and* grandchildren can also be included. Additionally, particular consideration could to be given to offering enjoyable family activities (e.g., picnics or family outings). While many interventions for grandfamilies are already structured in these ways, they may be less available and accessible to grandparents living in rural areas or to those experiencing compromised health. Thus, professionals might consider offering home-based therapy services or services located in settings grandparents already frequent (e.g., schools, churches). Further, mental health professionals might consider partnering with other community services and practitioners, or taking a multimodal approach, to better address the breadth of needs grandfamilies often experience.

Because grandchildren experience difficulties that are stressful for their grandparents and have significant potential consequences for the grandchildren's future development, the findings from this study suggest that mental health professionals should actively work to address the needs of grandchildren and support grandparents in their efforts to raise healthy, well-adjusted children. For

example, family therapists, with their knowledge of family systems dynamics, are especially suited to treat grandchildren's needs within the context of their larger family system. More specifically, family therapists could address problematic family dynamics (e.g. hierarchy, boundaries, power, communication), which are likely to have been in place for multiple generations, and can provide grandchildren with opportunities to express themselves and process their reactions to their family situation (Bartram, 1994; Bratton et al., 1998; Brown-Standridge & Floyd, 2000; Lander, 2011). As grandchildren's needs tend to be varied, connecting grandchildren to other resources and services such as medical care, mentoring, career counseling, and tutoring suggests that a multimodal perspective would best address grandchildren's needs.

The finding that mental health professionals could improve their services by monitoring their own biases and learning more about grandfamilies highlights the need for enhanced training. It is essential that professionals become knowledgeable about grandfamilies, as service recipients may feel frustrated when they perceive that they must teach others about their family. The content of trainings could include information about the formation of grandfamilies, challenges facing grandparents, resilience among grandfamilies, and the experiences of grandparents and grandchildren. Trainings could also address diversity within grandfamilies. Certainly, as demonstrated by the finding that grandfamilies wanted everyone's voice to be acknowledged and heard, mental health professionals should be cautious to avoid a one-size-fits-all approach. However, some basic knowledge may positively impact grandfamilies' relationships with mental health professionals and enhance their view of the services and resources within their communities.

Related to enhancing professional training, mental

health professionals could also benefit from attending to the personal assumptions underlying their work. In this study, grandmothers and grandchildren felt judged by the professionals with whom they have had contact. As such, these professionals could examine their feelings about grandfamilies and obtain adequate supervision and guidance to discuss how these feelings might be impacting their work. In particular, mental health professionals could explore their assumptions about grandfamily formation, grandparents' motivations, grandparents' parenting abilities, and grandchildren's level of functioning.

Grandmothers also indicated a preference for action-oriented treatment focused on helping them achieve their goals. As such, mental health professionals and other service providers might consider incorporating solution-focused therapy (de Shazer, 1988) techniques such as setting achievable goals, finding exceptions to problems, and identifying solutions that have worked in the past. A related approach that may be beneficial is narrative therapy (White & Epston, 1990), which focuses on helping grandparents create new, more resilient narratives about themselves and their families. Several participants shared that their experiences were not like others and that they wanted the professionals they work with to value their experiences, rather than make assumptions about them. Narrative therapy (White & Epston, 1990) has become known for its not-knowing, curious stance and its ability to honor clients' stories. Narrative therapists can help grandparents and grandchildren understand, address, and build upon the empowering stories in their lives (Freedman & Combs, 1996). This modality would also give grandfamilies the ability to process and reflect on their journey without feeling judged. Thus, combining a strong professional relationship, a multimodal perspective, future-oriented problem solving, and resilient narratives may provide grandfamilies with the most efficacious approach

to intervention. Grandfamilies can feel heard and supported, while also taking an active role in overcoming the challenges within their everyday lives.

The findings from this study also have implications for research. Grandmothers and grandchildren's recommendations for mental health professionals focused on facets of the relationship with the service provider and components of service. Despite this important information, the overall effectiveness of interventions with grandfamilies continues to receive limited empirical attention. Therefore, future research could examine the effectiveness of family therapy, support groups, psychoeducational programs, and community programs in terms of improving outcomes for custodial grandparents and their grandchildren. Part of this research could also examine the process of treatment and intervention, for the purpose of determining what specific facets of interventions have the most significant impact on desired outcomes. Finally, although this study considered the perspectives of grandchildren, which others have not done, researchers still need to know more about grandchildren's experiences with services.

Conclusion

Grandfamilies frequently access or are referred to mental health professionals and community services. To improve professional work with grandfamilies, service providers need to know how actual service recipients, including grandchildren, experience the services they utilize. The findings from this study suggest that various professionals working with grandfamilies can improve their work by attending to a genuine professional relationship and designing services that are responsive to grandfamilies' unique needs. However, to truly support grandfamilies, professionals should also consider joining grandparent

caregivers in their efforts to advocate for increased rights and recognition.

Acknowledgments: The authors gratefully acknowledge the financial support for this project provided by the Purdue Research Foundation Summer Research Grant and the Indiana Association for Marriage and Family Therapy Graduate Student Research Award.

Correspondence: Kendra A. O’Hora, Family Therapy Center of Virginia Tech (0515), 840 University City Boulevard, Suite 1, Blacksburg, VA 24060; Email: kendraaa@vt.edu; Phone: (540) 231-7201; FAX: (540) 231-7209.

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*Practice Brief***Critical Self-Reflection Questions for
Professionals Who Work with Grandfamilies**

Megan L. Dolbin-MacNab
Virginia Tech
Blacksburg, VA

Abstract

One of the reasons that grandparents raising grandchildren may not receive needed services is because they perceive professionals as being judgmental or holding negative attitudes toward them. As such, it is important for human service professionals to critically examine their opinions and attitudes toward grandfamilies, within the context of larger social structures, for the purposes of identifying those views that might interfere with the delivery of high quality services. This practice brief provides an overview of critical self-reflection questions that can be used, in a variety of ways, for training purposes. By utilizing these critical self-reflection questions, professionals can discover biases or attitudes that can then be addressed or challenged, to ensure that grandfamilies feel supported, respected, and affirmed by the professionals with whom they come into contact.

Keywords: grandparents raising grandchildren, critical self-reflection, service delivery, training

Despite having a variety of service needs, grandparents raising grandchildren may fail to seek needed services because they are discouraged or offended when they encounter professionals who have little understanding

of their family situation, hold misperceptions about their families, or are judgmental (Dolbin-MacNab, 2005; Dowdell, 1994; Gladstone, Brown, & Fitzgerald, 2009; Gibson, 2002; Hayslip & Glover, 2008). Negative biases among professionals may have a basis in larger society; for instance, burgeoning research indicates that young adults and traditional grandparents view custodial grandparents more negatively when grandchildren have problems (Hayslip & Glover, 2008; Hayslip, et al., 2009). Custodial grandparents are also viewed more negatively when the circumstances contributing to the caregiving arrangement are less socially acceptable (e.g., drug abuse, child abuse/neglect; Hayslip et al., 2009) or interpreted as being within the grandparents' control (Hayslip & Glover, 2008).

In addition to biases associated with family structure, pervasive ageism can result in professionals viewing older grandparents as incompetent, physically and cognitively impaired, and interpersonally difficult (Cuddy, Norton, & Fiske, 2005; Kite, Stockdale, Whitley, & Johnson, 2005; Nelson, 2002; Palmore, 2005). Given that custodial grandparents are frequently women, racial/ethnic minorities, and living in poverty (Annie E. Casey Foundation, 2012; Pew Research Center, 2010), professionals' negative stereotypes and biases related to these issues may further contribute to grandparents' feelings of being judged and stigmatized. Indeed, intersectionality (Collins, 2000) highlights that "cultural patterns of oppression are not only interrelated but are bound together and influenced by the intersectional systems of society, such as race, gender, class, and ethnicity" (p. 42). Thus, grandfamilies may be at risk of marginalization, oppression, and discrimination by human service professionals (and larger society) due to any number of social identities that combine to elevate their risk.

When professionals fail to understand grandfamilies or hold negative stereotypes about their family structure

and social identities, this disconnect can result in a strained professional relationship or a frustrating service experience (Dolbin-MacNab, 2005; Dowdell, 1994; Gladstone et al., 2009; Gibson, 2002; Hayslip & Glover, 2008). Lack of information and biases about grandfamilies can also result in grandparents having to “teach” professionals about their caregiving arrangement. While taking an open-minded, respectful, and curious stance has been noted as being a central component of culturally competent practice (Dyche & Zayas, 1995), the necessity of basic information about a particular group (or presenting issue) has also been noted as a component of effective intervention with diverse populations (Sue, 1998; Sue, Arredondo, & McDavis, 1992). Thus, some grandparents may feel resentful if a professional is unaware of general information about their family constellation or services available to them (Gibson, 2002). For instance, I once worked with a grandmother who was angry about having to teach her caseworker the laws in her state related to enrolling her grandchildren in school. Finally, an additional consequence of a lack of understanding or negative stereotypes on the part of practitioners could be grandparents receiving poorer quality services (Berrick, Barth, & Needall, 1994) or choosing not to seek services at all, due to the anticipation of a negative experience.

In my professional work with grandfamilies, which includes clinical practice (i.e., family therapy and support groups), consulting with practitioners who provide service to grandfamilies, and research on service delivery, I have encountered a number of specific misperceptions or negative assumptions that might underlie professionals’ negative or disrespectful attitudes toward grandfamilies. These beliefs, some of which are documented in the literature, may be held by professionals, but can also be held by custodial grandparents themselves. One of these beliefs is that grandparents raising grandchildren have

failed as parents and will continue the bad parenting practices they used with their own children (Gibson, 2002; Hayslip et al., 2009; Peters, 2005). Another is that grandparents are completely overwhelmed by their caregiving responsibilities, which makes them unable to provide quality care for their grandchildren (Dolbin-MacNab, Johnson, Sudano, Serrano, & Roberto, 2011). In accordance with widespread negative stereotypes about older adults (Cuddy et al., 2005; Kite et al., 2005; Nelson, 2002; Palmore, 2005), there are also those who believe that grandparents are too old to be raising grandchildren or are to blame for their situations (Gibson, 2002; Hayslip & Glover, 2008). Other beliefs include feeling sorry for grandparents, assuming that grandparents “don’t mind” raising their grandchildren because it is culturally normative, or assuming that grandfamilies do not need outside supports, as “families should just step up and take care of their own” (Dolbin-MacNab et al., 2011). Finally, I have observed statements implying that children being raised by grandparents are “damaged” and unlikely to overcome their challenges and succeed as adults. This perception is often linked back to failures of the parents and the grandparents and phrased as “well, the apple doesn’t fall far from the tree” (Dolbin-MacNab et al., 2011).

In considering the accuracy of these perspectives, research suggests that grandchildren may have higher rates of emotional and behavioral problems, when compared to other children (Billing, Ehrle, & Kortenkamp, 2002; Smith & Palmieri, 2007). There is also evidence that some grandparents may struggle with their parenting responsibilities (Hayslip & Shore, 2000) and use less-than-ideal parenting skills (Smith, Palmieri, Hancock, & Richardson, 2008; Smith & Richardson, 2008). Nonetheless, many grandparents also find raising their grandchildren to be a positive, rewarding, and fulfilling experience (Waldrop & Weber, 2001). Moreover, in spite

of experiencing very real stressors, grandparents and grandchildren demonstrate a wide range of resilient characteristics and positive outcomes, regardless of the structure of the family and the circumstances underlying the caregiving arrangement (Hayslip & Smith, 2013). In addition, there is evidence that custodial grandparents play an important role in preserving familial relationships, upholding cultural traditions, and maintaining community connections (Kopera-Frye & Wiscott, 2000). There is also evidence that being cared for by a relative (versus a non-relative) may be associated with better outcomes for children who have been removed from their homes (Winokur, Holtan, & Valentine, 2009).

When contemplating professionals' biases about grandfamilies, particularly in light of intersectionality (Collins, 2000), it is important to remember that these families are extremely diverse in terms of their demographic characteristics, needs, and experiences (Stelle, Fruhauf, Orel, & Landry-Meyer, 2010). For instance, grandfamilies are ethnically diverse and span the entire socioeconomic spectrum (Stelle et al., 2010). They are also diverse in terms of structure; grandchildren may be raised in two-grandparent or single grandparent homes, they may or may not have siblings or cousins living in their grandparents' homes, and they may live in homes with or without their parent(s) present (Ellis & Simmons, 2014). Additionally, for those unfamiliar with grandfamilies, it is easy to assume that these families form as the result of some type of failure or negative behavior on the part of the grandchild's parents or even the grandparents. Yet, grandfamilies form for a myriad of reasons that reflect a complex confluence of personal, relational, and contextual circumstances (Dolbin-MacNab & Hayslip, 2014). Clearly, it is difficult to make sweeping generalizations about the structural or interpersonal characteristics of grandfamilies. Not all grandfamilies are alike and, due to the cultural

patterns of oppression associated with the intersection of various social identities (Collins, 2000), some grandfamilies may be more at risk for experiencing misconceptions and negative stereotypes than others.

Addressing Professional Biases with Critical Self-Reflection

Based on the research literature, it is clear that many assumptions about grandfamilies may not be entirely true (certainly not in all cases) and that interacting with professionals who hold these misconceptions may leave grandfamilies feeling stigmatized or judged (Dolbin-MacNab, 2005; Dowdell, 1994; Gladstone et al., 2009; Gibson, 2002; Hayslip & Glover, 2008). When grandfamilies experience negative attitudes and stereotypes from the professionals with whom they interact, it can be due to the professionals' lack of exposure or experience with grandfamilies (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). As such, providing educational workshops can be a valuable strategy for increasing professionals' knowledge of grandfamilies, combating negative stereotypes, and reducing stigma.

Even with accurate information, professionals may still hold biases that can emerge, sometimes unintentionally or with great subtlety, in their work with grandparents and grandchildren. For this reason, and in accordance with classic approaches to teaching practitioners to work with diverse populations (McGoldrick, Giordano, & Pearce, 1996; Sue et al., 1992), training professionals to work with grandfamilies should involve going beyond simply giving information about grandfamilies. That is, practitioners should also be encouraged to be reflective about their practice and examine the personal biases and assumptions they bring to their work with grandfamilies. They should also consider how these perspectives impact the quality of the services they provide (McGoldrick et al., 1996; Sue et al., 1992).

In numerous disciplines, reflective practice has been described as an important means of providing diverse clients with effective and respectful services (e.g., Brookfield, 2009; Heron, 2005; Hoffman, 1985; McGoldrick et al., 1996). Unfortunately, reflective practice has been referred to by a number of terms that are often used interchangeably, but are actually distinct (e.g., self-awareness, self-reflection, reflexivity, self-reflexivity, self-of-therapist). To combat the confusion that can result from the imprecise use of terms, I am situating this particular discussion within the concept of “critical self-reflection.” For professionals in contact with grandfamilies, engaging in critical self-reflection is an important process by which they can carefully examine their views toward grandfamilies, for the purposes of gaining awareness of how those views might impact their work with grandparents and their grandchildren. In accordance with intersectionality (Collins, 2000), professionals can also use critical self-reflection to discover the marginalizing power dynamics and oppressive social discourses related to gender, age, class, race, and ethnicity that can become part of professional practice (Brookfield, 2009; Heron, 2005). With that in mind, professionals can then develop strategies to empower grandfamilies and provide them with the best services possible.

In the context of reflective practice, critical self-reflection goes beyond reflecting on one’s professional behavior or personal experiences influence professional interactions (Brookfield, 2009). Critical self-reflection also includes an explicit consideration of the power dynamics and social structures associated with one’s practice (Heron, 2005; Brookfield, 2009). Practitioners who engage in critical self-reflection recognize that “the self is, then, a co-constructor of a social reality and cannot escape playing a part in (re)producing the structures of society” (Heron, 2005, p. 344). As such, critical self-reflection invites

professionals to uncover and challenge the power dynamics present in their practice, as well as the assumptions they make about appropriate approaches to intervention. This stance also encourages professionals to consider how their work might reflect and perpetuate dominant social discourses related to grandfamilies' social identities (Brookfield, 2009).

In order to promote critical self-reflection among professionals who work with grandfamilies, the remainder of this brief provides a series of critical self-reflection questions that professionals can use to uncover potentially harmful (or helpful) attitudes and beliefs about grandfamilies. They also challenge professionals to consider intersectionality (Collins, 2000), power dynamics, and larger social discourses as they apply to practice with grandparents and grandchildren. After exploring these issues, professionals can then consider strategies for combating those factors that may negatively impact their work with grandfamilies. Specific suggestions for how to utilize these questions to improve service delivery are also discussed.

Critical Self-Reflection Questions

In order to improve service delivery by promoting critical self-reflection among professionals who work with grandfamilies, a selection of the following questions could be used for reflection and discussion:

- ✓ Why do grandfamilies form? To what extent are grandparents responsible for their situations?
 - What, in your life (e.g., past professional experiences, professional observations, social identities, etc.), contributes to these views?

- How might you be intentionally or unintentionally communicating these views to grandfamilies?
- In what ways have grandparents' social identities or larger contexts contributed to them having to take responsibility for their grandchildren?
- ✓ What strengths do grandfamilies possess? How do these strengths facilitate their success?
 - In what ways do you facilitate (or block) grandfamilies from recognizing and utilizing their strengths?
 - In what types of grandfamilies are you more or less likely to see strengths?
- ✓ What challenges do grandfamilies experience? How do these challenges develop? How do these challenges shape what grandfamilies need in terms of support?
 - How are your views of these challenges informed by your social identities and/or larger social discourses?
 - In what ways do you perpetuate or combat these challenges in your practice?
 - How might some of these challenges be responses to larger contextual issues or power differentials?
 - To what extent might these challenges also be strengths or resources?
- ✓ What are your opinions about grandparents' parenting skills? To what extent do you see them as having valuable experience or wisdom versus being in need of parent training?

- ✓ How have your professional interactions and experiences shaped your views (positively or negatively) of grandfamilies?
 - How have agency policies or your training influenced those views? How do they reflect dominant social discourses or intersectionality? (Collins, 2000)
 - How are you and the grandfamilies you work with “both empowered and disempowered” in your professional relationship? (Heron, 2005, p. 349)
 - What do you intend to accomplish and/or how do you intend to behave in your work with grandfamilies? How have those intentions developed, and how might they be helpful or harmful to grandfamilies? (Heron, 2005)
- ✓ What personal experiences have you had with grandfamilies? Were those experiences positive, negative, or neutral?
 - How do those personal experiences shape your work with grandfamilies?
 - How do those personal experiences perpetuate or challenge disempowering perspectives on grandfamilies?
- ✓ What do grandfamilies need to be successful?
- ✓ What biases or blind spots do you have in relation to grandfamilies? How might these biases or blind spots impact your efforts to help grandfamilies be successful?
- ✓ What biases or assumptions about grandfamilies do you see in in larger society?
 - To what extent do you agree or disagree with them? How might you, intentionally or

unintentionally, communicate these views to grandfamilies?

- How do these views reflect issues of intersectionality and power differentials?
- ✓ Based on your responses to these self-reflection questions, what could you do to improve the quality of services you deliver to grandfamilies?
 - What can you do to shift your negative assumptions into more positive ones?
 - In what ways can you help empower grandfamilies to be successful or resilient?
 - How can you be more sensitive and responsive to issues of power, intersectionality, and social discourses that may marginalize grandfamilies?

Utilization of the Critical Self-Reflection Questions

These critical self-reflection reflection questions can be used in a number of ways, as part of various training or continuing education efforts. Not all of the questions would need to be used at any given time. Professionals could use the questions for personal exploration, perhaps reflecting on their responses to the questions in a journal or notebook. In a group setting, a facilitator or trainer could ask participants first to do some individual self-reflection on the questions and then facilitate a group discussion about participants' responses. Alternatively, a facilitator could divide participants into groups and give each group a few of the questions to discuss. The groups could then provide a summary of their discussion for the larger group. Consistent with a critical view (Brookfield, 2009), the facilitator should be prepared to challenge participants to view themselves and their professional behavior more critically, particularly within the contexts of their own social identities, intersectionality (Collins, 2000), and

dominant societal discourses related to age, class, race, ethnicity, and gender. In mental health work, supervisors could use these questions to promote critical self-reflection among their supervisees. Whatever the format, facilitators or supervisors may want to consider using these questions more than once, as professionals may gain new perspectives, and attitudes are likely to evolve and change over time. Additionally, trainers and supervisors should also be alert to variations in participants' willingness to examine critically themselves and their practice. Some professionals may be more open to this type of professional development than others – in these cases, facilitators may need to slow down their pace with the use of the questions or discuss a professional's reluctance in an individual setting.

Once professionals have worked through the critical self-reflection questions, facilitators or trainers can then provide research-based education about the misconceptions or false assumptions being made. They can also carefully draw the connection between professionals' assumptions, biases, and their professional behavior, particularly in relation to larger social forces. Professionals could then be guided in a process of conceptualizing alternative practice strategies for working with grandfamilies. For example, a professional could be guided to identify her assumption that custodial grandparents are to blame for their situations and helped to link that assumption to her own biases about families living in poverty. Then, she could be encouraged to realize how this assumption might result in her subtlety (or not) communicating this feeling to grandparents or not making adequate efforts to help grandparents access needed services. She could also be helped to realize how her bias further marginalizes a family that is already at risk. Perhaps after some additional education about the varied reasons that underlie the formation of grandfamilies and further self-reflection, the professional in this example might

intentionally work to find strengths in grandparents and make a concerted effort to learn more about their circumstances before jumping to conclusions about placing blame. In utilizing these critical self-reflection questions, it is important to note that many personal biases and assumptions may be difficult to challenge or change because they are deeply rooted in larger social structures and dominant societal discourses. As such, providing professionals with ongoing opportunities to reflect critically on themselves and their experiences working with grandfamilies is an essential part of quality service provision.

While much of the discussion here has been directed toward using these critical self-reflection questions with professionals who engage in a variety of human services, the questions can also be used in other settings. For instance, I have used these questions in a research setting, for the purposes of orienting my research assistants to the potential for their biases and assumptions to impact how they interview grandparents and grandchildren and how they analyze research data. One of my assistants, after reflecting on the questions, acknowledged that he “felt sorry” for the grandmothers we were interviewing because they were disadvantaged in so many ways. We discussed how, during the data analysis process, this resulted in him further disadvantaging our participants by inadvertently overlooking grandparents’ sources of resilience or times when they felt that their caregiving arrangement was not too stressful or challenging. By using these critical self-reflection questions, he was able to return to the data analysis with a more balanced and critical perspective, which ultimately improved the trustworthiness of the data analysis.

Beyond researchers and human service professionals, the critical self-reflection questions could also be used with teachers, medical providers, lawyers,

pastors, or any other professional that might work with grandfamilies. For example, teachers could use these questions to consider how they approach and respond to students being raised by grandparents. Additionally, the critical self-reflection questions could be useful to advocacy efforts – that is, some or all of the questions could be used to educate groups that may be in a position to influence laws and policies that impact grandfamilies. For instance, agency leaders could use the questions to consider how their organizations approach grandfamilies, which could help them realize that the eligibility criteria for their services might be too restrictive, that grandparents and grandchildren should be eligible for additional resources, or that the agency is perpetuating difficulties or biases that some grandfamilies experience when trying to access resources. Whatever the audience, by encouraging professionals to be critically self-reflective about themselves, within the context of larger social structures, it is then possible to devise strategies to support grandfamilies, so that they are not left feeling judged, misunderstood, marginalized, or disempowered.

Conclusion

Grandfamilies already experience a number of personal, logistical, and structural barriers to accessing and receiving needed services (Dolbin-MacNab, Roberto, & Finney, 2013). Feeling judged, misunderstood, or disrespected by the professionals charged with providing them with assistance (Dolbin-MacNab, 2005; Dowdell, 1994; Gladstone et al., 2009; Gibson, 2002; Hayslip & Glover, 2008) should not be an additional barrier. Despite the multitude of approaches to training practitioners to work with diverse populations and the growing literature on interventions and programs for grandfamilies, little attention has been given to how to best train professionals

to work effectively with grandparents and their grandchildren.

This practice brief introduces self-reflection as a key consideration when training professionals to provide respectful, high quality services to grandfamilies. Addressing self-reflection, particularly critical self-reflection (Brookfield, 2009; Heron, 2005), is a valuable addition to more traditional training approaches, which may only focus on imparting information about grandfamilies, their needs, and resources available to them. More specifically, by encouraging critical self-reflection, professionals can gain insight into and combat the biases and assumptions that result in grandparents feeling judged or unwelcome within a professional setting. Additionally, taking a critical stance provides professionals with the opportunity to examine and challenge the power dynamics and larger social structures at work in their practice (Brookfield, 2009; Heron, 2005). This type of critical stance is useful, as it can help professionals recognize and address how intersectionality (Collins, 2000) associated with grandparents' and grandchildren's various social identities (e.g., age, race, ethnicity, class, and gender) may increase their risk of marginalization, oppression, and discrimination. In sum, developing skills in critical self-reflection is a means by which professionals can learn to empower grandfamilies in ways that other approaches to training may not address.

While professionals who engage in critical self-reflection should be respectful to all grandfamilies and should avoid replicating oppressive power structures and dominant discourses related to grandfamilies' social identities, it is not a perfect training tool. For instance, professionals can be highly self-reflective and yet unwilling to alter problematic or oppressive points of view (Blasco, 2012). Critical self-reflection can also be particularly challenging (Heron, 2005), as it can be hard to separate

one's perspectives from broader societal views. Finally, it can also be difficult for well-intentioned practitioners to consider the ways that they may perpetuate negative stereotypes and oppressive patterns of interaction (Heron, 2005). Despite these challenges, when professionals can truly critically examine themselves and the services they provide, they are in a better position to advocate for and strengthen the grandfamilies who seek their help. It is for this reason that critical self-reflection should be considered a key component of comprehensive training for professionals who work with grandparents and their grandchildren.

Correspondence: Dr. Megan L. Dolbin-MacNab, Family Therapy Center of Virginia Tech (0515), 840 University City Boulevard, Suite 1, Blacksburg, VA 24060; Email: mdolbinm@vt.edu; Phone: (540) 231-6807; FAX: (540) 231-7209.

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National Research Center on Grandparents Raising Grandchildren

Mission

Our mission is to improve the well-being of grandparent-headed families by promoting best practices in community-based service delivery, and advancing the work of practitioners and scholars in the development, implementation and evaluation of new knowledge in the field.

Core Beliefs

Grandparents contribute to the preservation of whole family systems when taking on the responsibility of raising their grandchildren.

Grandchildren, as well as all children, deserve to be loved and cherished in safe and nurturing families.

Parents should have primary responsibility for their children, but when they are unable/unwilling to assume that role, grandparents should be given the resources and support to assume parental responsibilities.

Communities are better served by grandparents taking on the custodial care of their grandchildren, when needed.